

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09025

CERTIFICATE OF DEATH

09016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Clair Askins		First William	Middle Clair
4. DATE OF DEATH June 6,		Month June	Day 6
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 4, 1902		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 11 Days 2 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Ser. Worker		10b. KIND OF BUSINESS OR INDUSTRY Md. Health Dept.	11. BIRTHPLACE (County & State, or foreign country) Roscoe, Pa.
13. FATHER'S NAME Joseph Askins		14. MOTHER'S MAIDEN NAME Kate Bunting	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No.		16. SOCIAL SECURITY NO. 200-0700300	17. INFORMANT Mrs. Agnes Askins, Rohrersville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs		19. INTERVAL BETWEEN ONSET AND DEATH 1 yr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)			
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) -		(County) - (State) --	
21. I certify that (I) (this hospital) attended the deceased from Aug 23, 1965 , to June, 1966 , that (I) (we) last saw the deceased alive on June 6, 1966 , and that death occurred at 10 AM , from causes and on the date stated above.			
22a. SIGNATURE 		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-7-66
22c. PHYSICIAN'S NAME (Type) Dr. Harold R. Tritch, Jr MD		22d. ADDRESS 302 N. Potomac Street	Hagerstown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6- 8- 66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Locust Grove Cemetery
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St., Boonsboro, Md.		25a. RECEIVED BY REGISTRAR JUN 9 1966	25b. REGISTRAR'S SIGNATURE 

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH				09017			
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 117 Knotty Pine Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Robert Middle (none) Last Baillie				4. DATE OF DEATH Month June Day 23 Year 66 19			
S. SEX male white		6. COLOR OR RACE white		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) agent		10b. KIND OF BUSINESS OR INDUSTRY insurance co.		11. BIRTHPLACE (County & State, or foreign country) Kilbarchan, Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Baillie				14. MOTHER'S MAIDEN NAME Elspeth Doig			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 158-18-6421		17. INFORMANT Jean Warnwright, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic C-V Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, gsm.</u> Yes. (c) <u>Arteriosclerosis, gsm.</u> Yes.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diminished mental status.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>17 June</u> , 19 <u>63</u> , to <u>23 June</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>23 June</u> , 19 <u>66</u> , and that death occurred at <u>2:30 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <u>24 June 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>		22d. ADDRESS <u>218 N. Potomac St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6/25/66</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>MINNICH FUNERAL HOME</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		19618	
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND WASHINGTON											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN				c. LENGTH OF STAY IN 1b 6 DAYS				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GATEWAY CONV. HOME								e. STREET ADDRESS 804 S. POTOMAC STREET							
3. NAME OF DECEASED (Type or print) HANNA				First ELIZABETH	Middle BEAN	Last	4. DATE OF DEATH JUNE 13 1966	Month	Day	Year					
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1883	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING ROOM				10b. KIND OF BUSINESS OR INDUSTRY W.P.A.				11. BIRTHPLACE (County & State, or foreign country) HARDY CO., W. VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WADE H. LANDAKER				14. MOTHER'S MAIDEN NAME EMILY CARLISLE											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. SABILLA MESSERSMITH		HAGERSTOWN, MARYLAND									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Occlusion Arterioscl. Heart Disease with Aortic Valvular Disease												INTERVAL BETWEEN ONSET AND DEATH Instant		3 yrs (Unknown)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None												19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN		(County) MARYLAND		(State) MARYLAND			
21. I certify that (I) (this hospital) attended the deceased from Apr. 15, 1963 to June 13, 1966 , that (I) (we) last saw the deceased alive on Apr. 1, 1966 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.															
22a. SIGNATURE B.B. Kneisley				22b. DATE SIGNED 6/14/1966											
22c. PHYSICIAN'S NAME (Type) B.B. KNEISLEY M.D.				22d. ADDRESS 148 W. WASH. ST. HAGERSTOWN, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/16/1966		23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY				23d. LOCATION (City, town or county) HAGERSTOWN, MARYLAND				(State) MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER				ADDRESS HAGERSTOWN, MARYLAND								25a. REC'D BY REGISTRAR JUN 20 1966		25b. REGISTRAR'S SIGNATURE Charles J. Rouzer	

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
WASHINGTON		a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 6 MOS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1030 THE TERRACE				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First EVELYN	Middle MARIE	Last Beery BERRY			
4. DATE OF DEATH JUNE 8 1966	Month Day Year					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1904			
9. AGE (in years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY ORGAN MFG.	11. BIRTHPLACE (County & State, or foreign country) HUDSON CO., N. JERSEY			
13. FATHER'S NAME JOHN M. FREUND		14. MOTHER'S MAIDEN NAME EVA JONES	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Beery HAGERSTOWN, MARYLAND C. LYNWOOD BERRY 1030 THE TERRACE			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Ca of breast (approximately) (c)		INTERVAL BETWEEN ONSET AND DEATH about 2 1/2 yrs 20 years -				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) HAGERSTOWN	(County) MARYLAND	(State)
21. I certify that (I) (this hospital) attended the deceased from 9-16, 1966, to 6-8, 1966, that (I) (we) last saw the deceased alive on 6/8, 1966, and that death occurred at 8:15 A.M., from the causes and on the date stated above.						
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 6/9/1966				
22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER M.D.		22d. ADDRESS 154 W. WASH. ST. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/11/1966		23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY		23d. LOCATION (City, town or county) HAGERSTOWN, MARYLAND
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND		25a. RECD BY REGISTRAR DATE JUN 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge		

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Items 1b, 1d Film G577 6/14/66 mn

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN Hancock		c. LENGTH OF STAY IN 1b 20 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLUE HILL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Doctor's office, 250 E. Main St.		e. STREET ADDRESS HANCOCK MD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GUY MC KINLEY BENNETT		First GUY	Middle MC KINLEY
Last BENNETT		4. DATE OF DEATH 6 4 19 66	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12.17.99		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMAN		10b. KIND OF BUSINESS OR INDUSTRY LUMBER	11. BIRTHPLACE (County & State, or foreign country) ARTEMAS BEDFORD PENNA.
13. FATHER'S NAME SAMUEL A BENNETT		14. MOTHER'S MAIDEN NAME ZELLA J LASHLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217.07.9929	17. INFORMANT Address NAOMI BIMES RURAL 1 FLINTSTONE MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest -11:50 AM DUE TO 3220 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) acute alcoholism DUE TO lost (c) severe malnutrition and dehydration			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to June 4, 1966 that (I) (we) last saw the deceased alive on June 4, 1966, and that death occurred at 11:55 am causes and on the date stated above.			
22a. SIGNATURE Charles R. Wierer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 7, 1966
22c. PHYSICIAN'S NAME (Type) Charles R. Wierer, M.D.		22d. ADDRESS 238 E. Main St., Hancock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6.7.66	23c. NAME OF CEMETERY OR CEMETORY FLINTSTONE ODD FELLOWS
24. FUNERAL DIRECTOR Howard & Son Hancock Md.		ADDRESS JUN 9 1966	25a. REC'D BY REGISTRAR Charles Judge
25b. REGISTRAR'S SIGNATURE Charles Judge			

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1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 16 YRS.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1319 HAMILTON BLVD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MABEL	Middle LOUISE	Last BOHMAN		
4. DATE OF DEATH JUNE 13 1966	Month	Day	Year		
5. SEX FEMALE	6. COLOR DR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 10, 1885		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.		
13. FATHER'S NAME GEORGE F. PYLE	14. MOTHER'S MAIDEN NAME MARY HINWOOD	11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE CO., MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. -----	17. INFORMANT O. P. BOHMAN	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Thrombosis (arterioscl.)</i>	INTERVAL BETWEEN ONSET AND DEATH 5 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>By extension Cardiac Disease (Arteriosclerosis, with congestive failure)</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>148 W. WASH. ST. HAGERSTOWN, MD.</i>	20f. (City or town) <i>HAGERSTOWN, MARYLAND</i>	(County) <i>MARYLAND</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from Apr 4, 1960 to June 13, 1966 , that (II) (we) last saw the deceased alive on June 13, 1966 , and that death occurred at 11 P.M. from the causes and on the date stated above.	22b. DATE SIGNED <i>6/14/1966</i>				
22a. SIGNATURE <i>B.B. Kneisley</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) B.B. KNEISLEY M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/16/1966	23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY	23d. LOCATION (City, town or county) <i>HAGERSTOWN, MARYLAND</i>	(State) <i>MD</i>	
24. FUNERAL DIRECTOR CHARLES M. ROUZER	ADDRESS <i>HAGERSTOWN, MARYLAND</i>	25a. REC'D BY REGISTRAR JUN 20 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Rouzer</i>		



M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09023

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
WASHINGTON MARYLAND		MARYLAND WASHINGTON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
HAGERSTOWN	3 MOS.	HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FRIENDSHIP MANOR CONV. HOME		20 W. FRANKLIN STREET	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle LEWIS	Last BOYD
4. DATE OF DEATH	JUNE	Month 30	Day 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JUNE 10, 1887
9. AGE (in years last birthday)	79 yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED MAINTENANCE MAN	HOSPITAL	WASHINGTON CO., MARYLAND	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
THOMAS BOYD	SARAH MACARTER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
NO	214-09-1846	MRS. ELIZABETH BOYD	HAGERSTOWN, MARYLAND
INTERVAL BETWEEN ONSET AND DEATH 72 hrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
Cerebral Thrombosis			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b) Cerebral Arteriosclerosis	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966, to June 21, 1966, that (I) (we) last saw the deceased alive on June 21, 1966, and that death occurred at 12 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert P. Conrad		22b. DATE SIGNED 6/30/1966	
22c. PHYSICIAN'S NAME (Type) ROBERT P. CONRAD M.D.		22d. ADDRESS 137 W. WASH. ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 2, 1966	23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	25d. REGISTRAR'S SIGNATURE Charles Judge
		25a. REC'D BY REGISTRAR	25b. DATE JUL 5 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~fill in~~ carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
OSC32

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09024

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE		Maryland b. COUNTY			
						Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Hagerstown		1 hr.		Sharpsburg		111 E Chapman St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM?			
Washington County Hospital						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Joseph		Gloss	over	over	June 7			1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
M		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 4 1992	74 yrs.	Months 3	Days 3	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		None		Washington		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Joseph Gloss		Jennie Michael							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		none		Mr. Owen W. over		Sharpsburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Insufficiency				5 days			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Pulmonary Emphysema with Fibrosis						
		DUE TO (c)	Pleurisy with effusion						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Arteriosclerotic		XXXXXX cardiovascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 27, 1966, to June 7, 1966, that (I) (we) last saw the deceased alive on June 7, 1966, and that death occurred at 3:15 p.m. from the causes and on the date stated above.						22b. DATE SIGNED			
22a. SIGNATURE <i>Rizalito Amarillo</i>						June 8, 1966			
22c. PHYSICIAN'S NAME (Type)		Rizalito Amarillo, M.D.		22d. ADDRESS		23d. LOCATION (City, town or county) (State)			
				120 W. Main St. Sharpsburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)			
Burial		June 11-66		Mt. View Cemetery		Sharpsburg			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Alberto. Amarillo. c. m. o. r. s. .				JUN 13 1966		<i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09025

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) RURAL WILLIAMSPORT		c. LENGTH OF STAY IN 1B 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC FISH & GAME CLUB		e. STREET ADDRESS 766 NORTHERN AVE.	
3. NAME OF DECEASED (Type or print) DOROTHY		First MILDRED	Middle BRINING
4. DATE OF DEATH JUNE 19 1966		Last BRINING	Month JUNE
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH DEC. 18, 1910		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY BOARD OF EDUCATION	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES ITNEYER	
14. MOTHER'S MAIDEN NAME BESSIE TROVINGER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 212-10-0051		17. INFORMANT HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Myocardial Infarction		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
DUE TO { Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease (c) Hypertensive Cardio Vasc - Disease		3 yrs. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work Not White at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 19, 1947 , to June 19, 1966 , that (I) (we) last saw the deceased alive on June 19, 1966 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED 6/20/1966	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 22, 1966	23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	25a. REC'D BY REGISTRAR JUN 27 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00034
00026

1. PLACE OF DEATH
e. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Co. Hospital

First
3. NAME OF
DECEASED
(Type or print)

MARYLAND

c. LENGTH OF STAY IN HB

3 Weeks

5. SEX

6. COLOR OR RACE

Male white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

Father

13. FATHER'S NAME

Calvin Burkett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

218-24-2040

17. INFORMANT

Mr. Lloyd Burkett, Jr.

3 Greencastle Rd.

Address

Franklin Co., Penna

USA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Septicemia

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last,

(b)

DUE TO

Septicemia

(c)

Gummosis

Burst, ruptured artery

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

White Not White

at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

to

that death occurred at

M, from the causes and on the date stated above.

22e. SIGNATURE

John J. Donoghue

M.D.

22f. ADDRESS

22g. ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22h. DATE SIGNED

John J. Donoghue

M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

6/10/1966

23c. NAME OF CEMETERY OR CREMATORIAL

Peddy Hill Cemetery

Greencastle Franklin Co.

23d. LOCATION (City, town or county) (State)

Greencastle Franklin Co.

24. FUNERAL DIRECTOR'S SIGNATURE

Howard K. Zimmerman

Greencastle, Pa.

ADDRESS

25e. REC'D BY REGISTRAR

JUN 10 1966

25f. REGISTRAR'S SIGNATURE

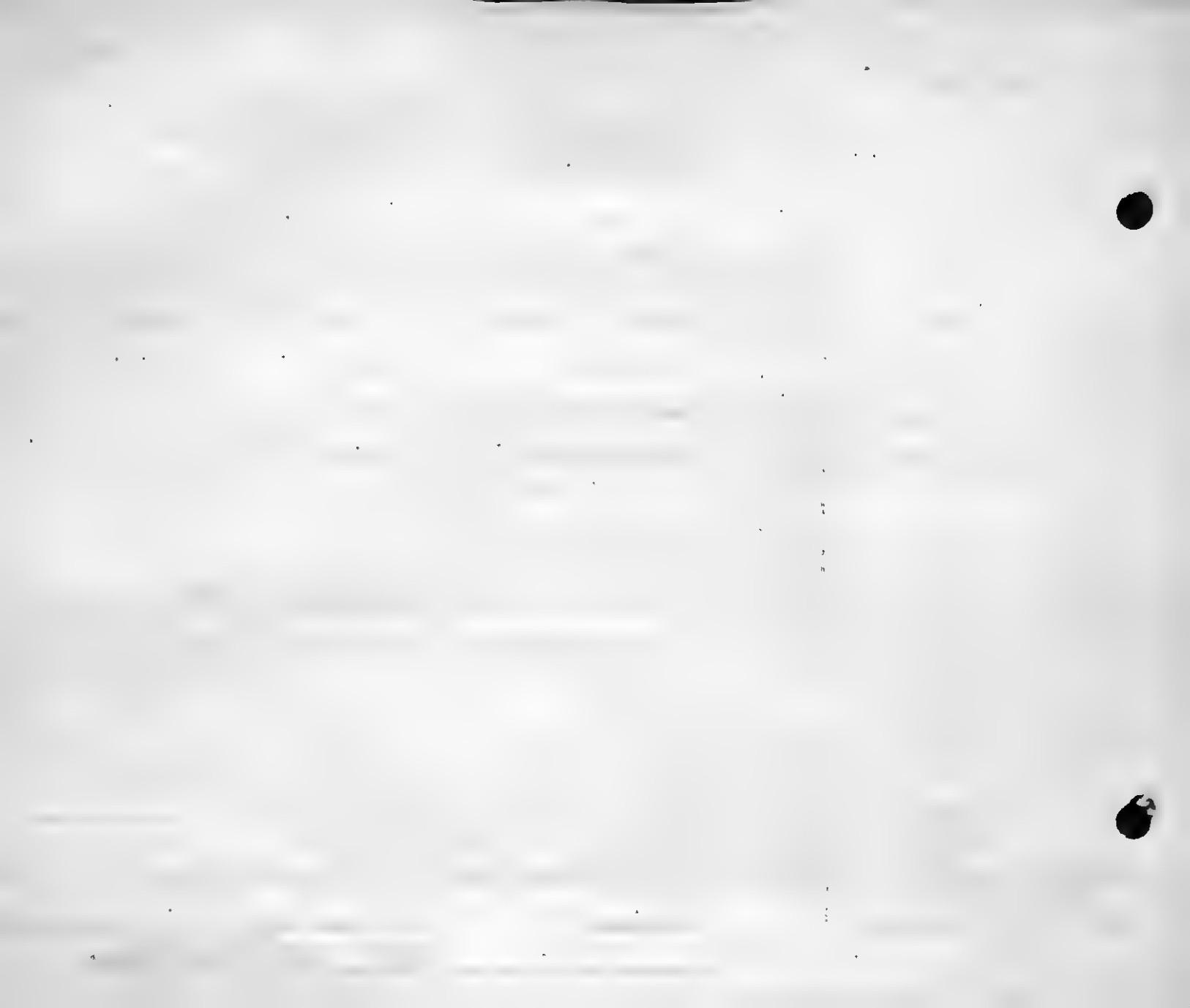
Charles Judge



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05C35 09027											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Bunzl Boonsboro)											
c. LENGTH OF STAY IN lb 3 yrs.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 201. Bunzl Boonsboro 1. RTD 12											
3. NAME OF DECEASED (Type or print) Lynn Johnny Bussard											
First Middle Last											
4. DATE OF DEATH June 10 1966											
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH July 25 1964											
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 yr. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 201. 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Boonsboro Md. U.S.A.											
13. FATHER'S NAME Johnny Lee Bussard 14. MOTHER'S MAIDEN NAME Patsy Campbell											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give year of entry to service) none Mr. Johnny T. Bussard Boonsboro Md. no											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 7290 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CAUSE OF DEATH. Fall into cistern on Farm -											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall into cistern on Farm -											
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not While 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour am. 4:00 p.m. 6/10/1966 at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Boonsboro Wash 14											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto III											
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.											
MEDICAL CERTIFICATION											
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREON 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State) Burial June 13-66 Mt. Vista Cemetery Sharpsburg Md.											
23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Albert L. Leaf Williamsport Md. JUN 14 1966 Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

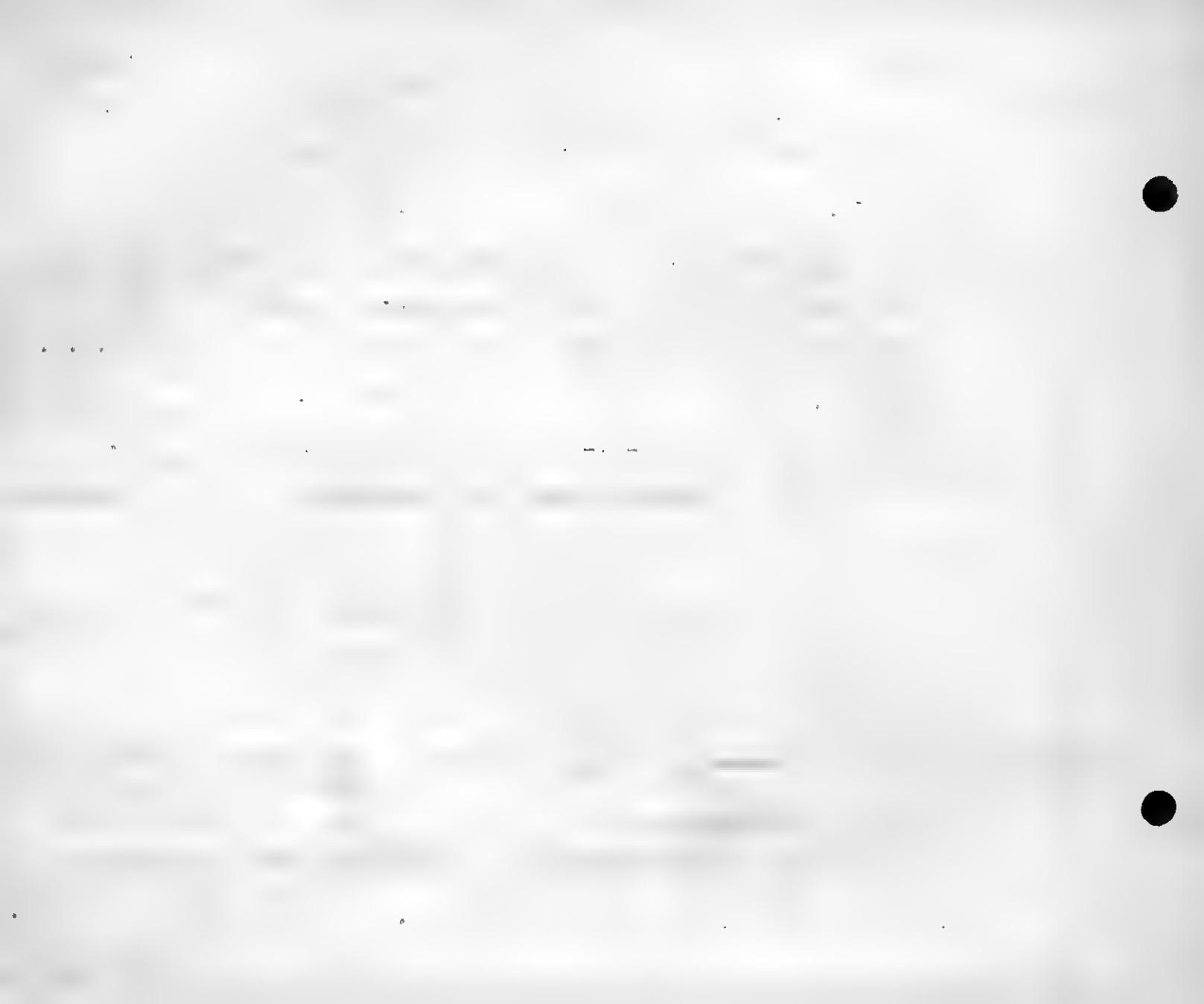
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09028
CSC36

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write HAGERSTOWN)				2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm ssion) a. STATE MARYLAND b. COUNTY WASHINGTON			
c. LENGTH OF STAY IN b. 60 YRS.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MD. STATE HOSPITAL				d. STREET ADDRESS 62 RANDOLPH AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First ANNA	Middle MARIE	Last COLLIFLOWER	4. DATE OF DEATH JUNE 15 1966	Month	Doy	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-12-1882	9. AGE (In years at birthday) 83 yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during working life, or retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
13. FATHER'S NAME ALBERT C. TRIGG				14. MOTHER'S MAIDEN NAME MARGARET KLINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 217-01-3400A		17. INFORMANT MRS. HOLMES HARPER		18. ADDRESS WINCHESTER VA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF MOUTH				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				DUE TO DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14- 1966 , to 10-15- 1966 , that (I) (we) last saw the deceased alive on 1-14- 1966 , and that death occurred at 642 1/2 M. from causes and on the date stated above.							
22a. SIGNATURE Antonio U. Palla Rosi				22b. DATE SIGNED 6-15-66			
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLA ROSI				22d. ADDRESS 1500 Plaza Ave Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/17/66		23c. NAME OF CEMETERY OR CREMATORIAL CEDAR GROVE CEM.		23d. LOCATION (City or Town) (County) (State) CHAMBERSBURG PENNA.	
24. FUNERAL DIRECTOR W. J. Horneat Hagerstown, Md.				25a. ADDRESS W. J. Horneat Hagerstown, Md.		25b. REC'D BY REGISTRAR JUN 20 1966	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		1966					
b. CITY OR TOWN (if outside corporate limits, write nearest town)		HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 yrs.		a. STATE MARYLAND		b. COUNTY WASHINGTON					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARLOCK MEM. CONV. HOSPITAL													
3. NAME OF DECEASED (Type or print)		First ALVEY	Middle ROBERTUS	Last COOK	4. DATE OF DEATH	JUNE	Month 3	Day 19	Year 66				
5. SEX		6. COLOR DR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY					
MALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6/7/1882	83 yrs.	TRUCK FARM.	MARYLAND	U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY							
RETIRED FARMER		TRUCK FARM.		MARYLAND		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
JOHN COOK		PHIANA ??											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO		212-24-5527		MR. RALPH COOK		HAGERSTOWN MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure													
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)													
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
INTERVAL BETWEEN ONSET AND DEATH Indefinite													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 3, 1966		(County)		(State)			
19													
21. I certify that (I) (this hospital) attended the deceased from June 1958, to June 3, 1966, that (I) (we) last saw the deceased alive on May 31, 1966, and that death occurred at Hagerstown, Maryland, from the causes and on the date stated above.													
22a. SIGNATURE <i>B.B. Kneisley</i>		22b. DATE SIGNED June 6, 1966											
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington St. Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE THEREOF 6/6/66		23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.		23d. LOCATION (City, town or county) HAGERSBROWN		(State) MD.					
24. FUNERAL DIRECTOR <i>W.T. Torment, Hagerstown, Md.</i>		ADDRESS DATE JUN 9 1966		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR A15 (4) 20M 1/65													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

CS038

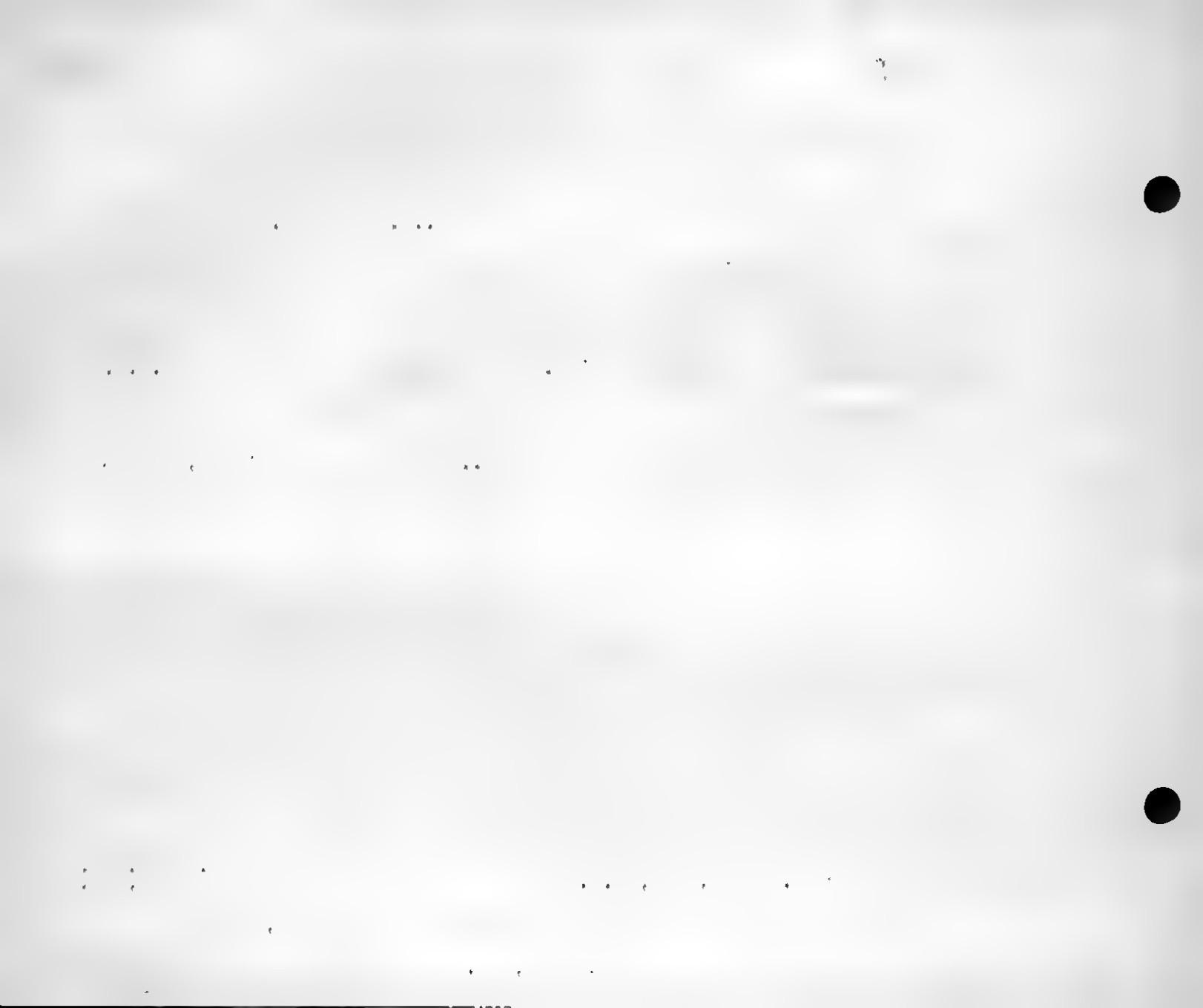
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09030

TO **ATTORNEY**: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

NO FUNERAL DIRECTOR: Page 3 should be used as a burial-troupe permit if pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown			b. COUNTY Dade		
c. LENGTH OF STAY IN b 6 hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Del Mar Inn			d. STREET ADDRESS 102 S.W. 16th Ave.		
3. NAME OF DECEASED (Type or print) Phillip Lazar Cook			4. DATE OF DEATH Month Day Year June 10 19 66		
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/5/1900	9 AGE (In years lost birthday) 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) representative			10b. KIND OF BUSINESS OR INDUSTRY liability ins.		
11. BIRTHPLACE (State or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no			16. SOCIAL SECURITY NO. Mrs. Irma Cook		
17. INFORMANT Mrs. Irma Cook			Address Miami, Florida		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion - DUE TO 42 / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Atherosclerosis (b) DUE TO Arteriosclerosis, generalized (c)			INTERVAL BETWEEN ONSET AND DEATH 15 Hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Edward W. Ditto III</i>	MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.			22. DATE SIGNED 6-10-66		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 6/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Southern Memorial	23d. LOCATION (City or Town) (County) (State) Miami, Florida		
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME	ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR JUN 13 1966			25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15ME (5) 6M 1/66					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09039

CERTIFICATE OF DEATH

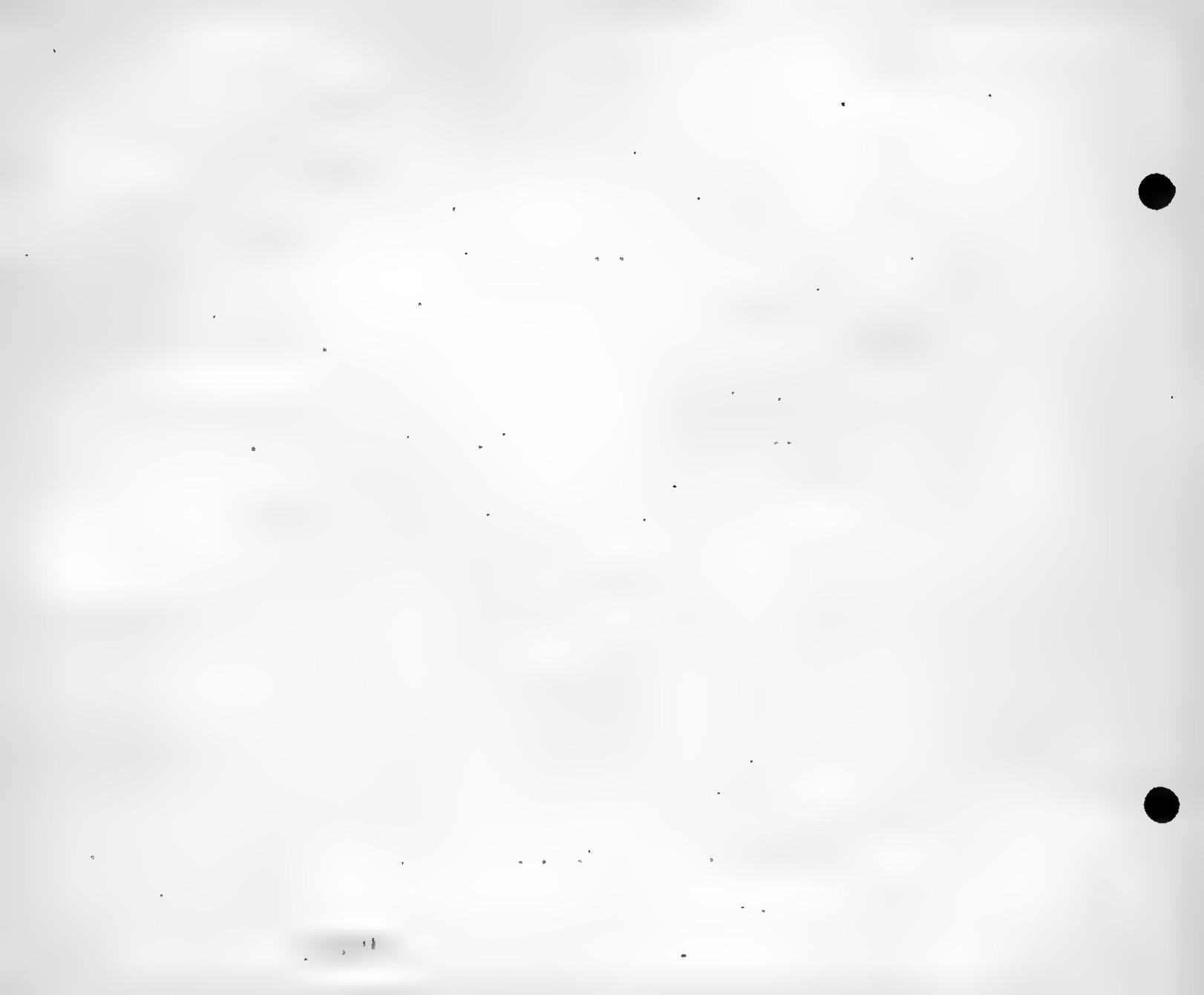
09031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First N.M.N.	Middle COOKE
4. DATE OF DEATH JUNE 26 1966		Last	Month Day Year
5. SEX FEMALE WHITE		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH AUG. 2, 1900
9. AGE (In years last birthday) 65 yrs.		10. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLYDE H. WILSON		14. MOTHER'S MAIDEN NAME MARY ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT HAGERSTOWN, MARYLAND MRS. EDGAR T. HAYMAN R.D.#. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 4200 DUE TO <i>Arteriosclerotic heart disease</i> 420.6 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> 420.6 (c) <i>Muscle atrophy, senile</i> 420.6 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Myocarditis, syphilitic</i>			
19. INTERVAL BETWEEN ONSET AND DEATH 1m			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on <i>June 26, 1966</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence L. Packer Jr.</i>		22b. DATE SIGNED 6/29/1966	
22c. PHYSICIAN'S NAME (Type) LAWRENCE L. PACKER JR. M.D.		22d. ADDRESS 145 W. WASH. ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION REMOVAL (Specify) CREMATION		23b. DATE THEREOF 6/30/66 23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORY	
24. FUNERAL DIRECTOR CHARLES M. ROUZER		23d. LOCATION (City, town or county) (State) WASHINGTON D.C. ADDRESS HAGERSTOWN, MARYLAND DATE JUL 1 1966 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

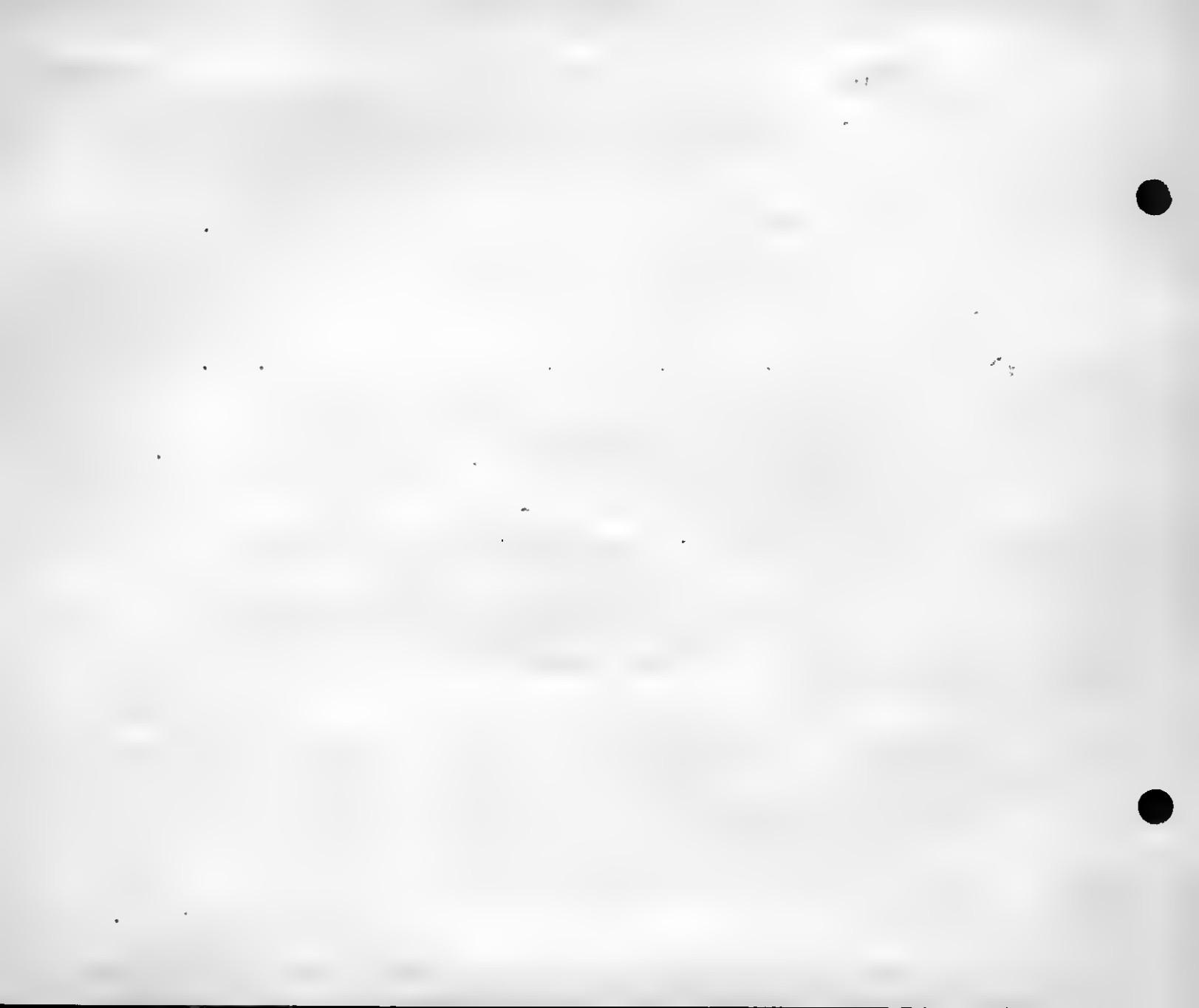
CERTIFICATE OF DEATH

19032

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 1153 Beachwood Dr.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CARSON	Middle SCOTT	Last COUCHMAN
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Elementary super		9. DATE OF BIRTH 9/9/12	
10b. KIND OF BUSINESS OR INDUSTRY Public school		9. AGE (In years last birthday) 53 yrs	
10c. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Howard Couchman		14. MOTHER'S MAIDEN NAME Ada Grove	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO 220-18-1902	
17. INFORMANT Mrs. Catherine Couchman, Hagerstown		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Atherosclerosis of Coronary/Arteries 4 yr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/14 , 19 62 , to 6/11 , 19 66 , that (I) (we) last saw the deceased alive on 4/22 19 66 , and that death occurred at 720P M, from causes and on the date stated above.		22b. DATE SIGNED 6/13/66	
22a. SIGNATURE Robert V. Campbell		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/15/66	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		ADDRESS Hagerstown, Md.	
VR A15 (4) 20 M 1/66		25a. REC'D BY REGISTRAR JUN 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

OSCG 3

CERTIFICATE OF DEATH

110033

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

MARYLAND

20 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1028 Woodland Way

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED NEVER MARRIED DIVORCED

8. DATE OF BIRTH

COVER

Jan. 13, 1893

June

23

19 66

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (County & State, or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

Myersville, Frederick Co U.S.A.

13. FATHER'S NAME

John C. Deter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

218-50-3052 Curtis C. Cover, 1028 Woodland Way,

Address Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (e))DUE TO
(b)
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(c)

Myocardial Infarction

ARTERIOSCLEROTIC HEART DISEASE

ARTERIOSCLEROSIS, GEN.

INTERVAL BETWEEN
ONSET AND DEATH
3 months

Yes.

Yes.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 14 April 1965, to 23 June 1966, that (I) (we) last saw the deceased alive on 29 April 1966, and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

W.N. FENDER

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
24 June 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial June 26, 1966 St. Paul's Lutheran

24 FUNERAL DIRECTOR'S SIGNATURE

Paul F. Bittle, Myersville, Md.

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE JUN 28 1966 Charles Judge

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~fill in~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA b. COUNTY FULTON						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN lb 2 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AMARANTH PENNA.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)		First GLADYS	Middle LEFAUNE	Last CRAWFORD	4. DATE OF DEATH Month 6	Month 3	Day 19	Year 66				
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.21.98			9. AGE (In years from birthday) 68 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) FULTON COUNTY PENNA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANCIS H LASHLEY						14. MOTHER'S MAIDEN NAME LORETTA LEHMAN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO 091 16 7715			17. INFORMANT JAMES W CRAWFORD 1812 CREST DRIVE HAGERSTOWN, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio vs. collapsed</i> DUE TO <i>brain</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Stroke</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>						
(b) <i>Cerebral hem. (left)</i> DUE TO <i>stroke</i>												
(c) <i>Arterio venous junction</i> DUE TO <i>stroke</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to June 3, 1966 , that (I) (we) last saw the deceased alive on June 3, 1966 , and that death occurred at BUCKVALLEY FULTON PENNA. M, from causes and on the date stated above.												
22a. SIGNATURE <i>Louis S. Gray</i>						22b. DATE SIGNED <i>6/5/66</i>						
22c. PHYSICIAN'S NAME (Type) <i>Louis S. Gray</i>			M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22d. ADDRESS <i>316 North Ave., Boyce</i>						
23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL			23b. DATE THEREOF 6.6.66			23c. NAME OF CEMETERY OR CREMATORIAL CHRISTIAN			23d. LOCATION (City or Town) (County) (State) BUCKVALLEY FULTON PENNA.			
24. FUNERAL DIRECTOR <i>Howard J. Shirey, Hanover Md.</i>						ADDRESS <i>101 N. Hanover St., Hanover, Md.</i>			25a. REC'D. BY REGISTRAR <i>JUN 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66												

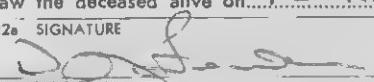


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 4 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 131 Blooms Ave.	
3. NAME OF DECEASED (Type or print) William Elmer Dixon		First	Middle
Last		4. DATE OF DEATH June 9 1966	Month Day Year
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 9 1881		9. AGE (in years (last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Office Building	
11. BIRTHPLACE (County & State, or foreign country) Luray, Va		12. CITIZEN OF WHAT COUNTRY USA.	
13. FATHER'S NAME Cyrus Dixon		14. MOTHER'S MAIDEN NAME Lena Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 332-05-6786	
17. INFORMANT Geraldine Burnett		Address 131 Blooms Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR DISEASE</u>			
4/2/61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis C V DISEASE</u>			
DUE TO (c) <u>Atherosclerosis, generalized</u>			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. I certify that (I) (this hospital) attended the deceased from 25/3 , 19 66 , to 10/1 June, 19 66 , that (I) (we) last saw the deceased alive on 9 June , 19 66 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE 			
M.D.			
22b. DATE SIGNED 13 June 1966			
22c. PHYSICIAN'S NAME (Type) W N FENDR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 218 N Potowmack St Hagerstown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-1966	23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
23d. LOCATION (City, town or county) Hagerstown Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.		ADDRESS John R Watson Jr. Hagerstown Md.	25a. REC'D BY REGISTRAR JUN 16 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



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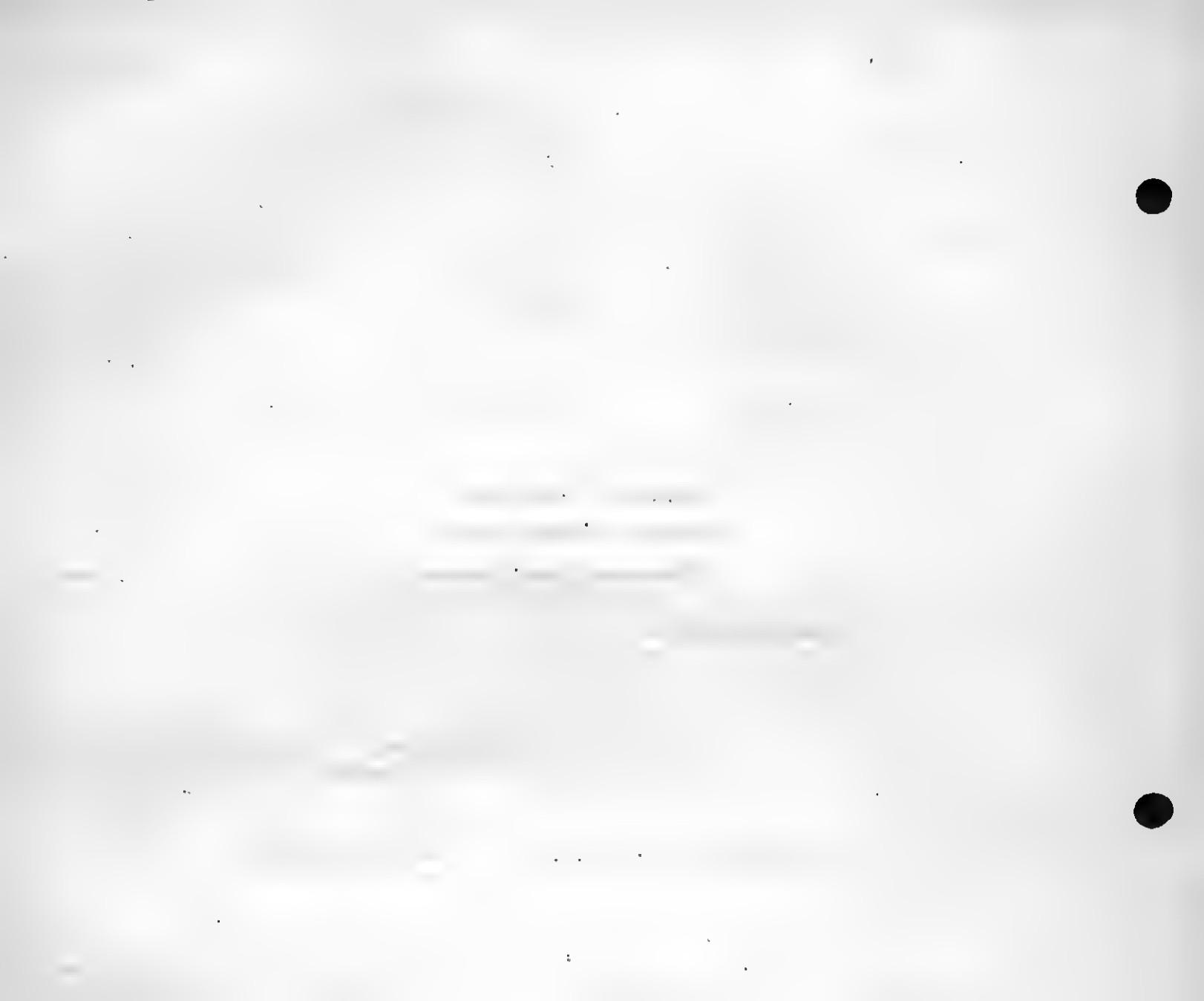
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09036

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		Hagerstown MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD2, Hagerstown		c. LENGTH OF STAY IN 1b 24 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD2, Hagerstown		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Olive	Middle May	Last Drury	4. DATE OF DEATH	Month June	Day 7	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1898	9. AGE (In years last birthday) 67 yrs.	10. UNDER 1 YEAR Months 6	11. UNDER 24 HRS. Days 7	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Broadfording Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira S. Kline		14. MOTHER'S MAIDEN NAME Lillie May Rice		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Fred N. Drury		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42-1 Myocardial Infarction	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. Coronary atherosclerosis		DUE TO (b) Rheumatic Heart Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 03, 1966 to June 07, 1966 , that (I) (we) last saw the deceased alive on June 07, 1966 , and that death occurred at 45A M. from the causes and on the date stated above.				22b. DATE SIGNED 06/07/66			
22a. SIGNATURE <i>Archie Robert Cohen</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Clear Spring, Maryland			
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Junell, 66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR <i>Conrad E. Thompson</i>				25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08045

CERTIFICATE OF DEATH

119037

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 PLACE OF DEATH a. COUNTY Washington MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN lb 10 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d STREET ADDRESS 110 N. Antietam St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First ELSIE	Middle MAE	Lost DUBEL	4 DATE OF DEATH June 10, 1966	Month Day Year		
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 13, 1918	9 AGE (In years last birthday) 48 yrs	f. UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Hagerstown, Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Ralph Funkhouser			14. MOTHER'S MAIDEN NAME Helen E. Baker				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17 INFORMANT Lewis Dubel, Funkstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Neutropenia, anemia, Thrombocytopenia</u> (b) <u>Myelogenous Leukemia</u> DUE TO <u>Diabetes mellitus</u> (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Death from diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 2, 1966, to June 10, 1966, that (I) (we) last saw the deceased alive on June 10, 1966, and that death occurred at M, from causes and on the date stated above.						22b. DATE SIGNED 12 June 66	
22a. SIGNATURE Charles Moody		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS			
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-13-66		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24 FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR JUN 16 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CS046

CERTIFICATE OF DEATH

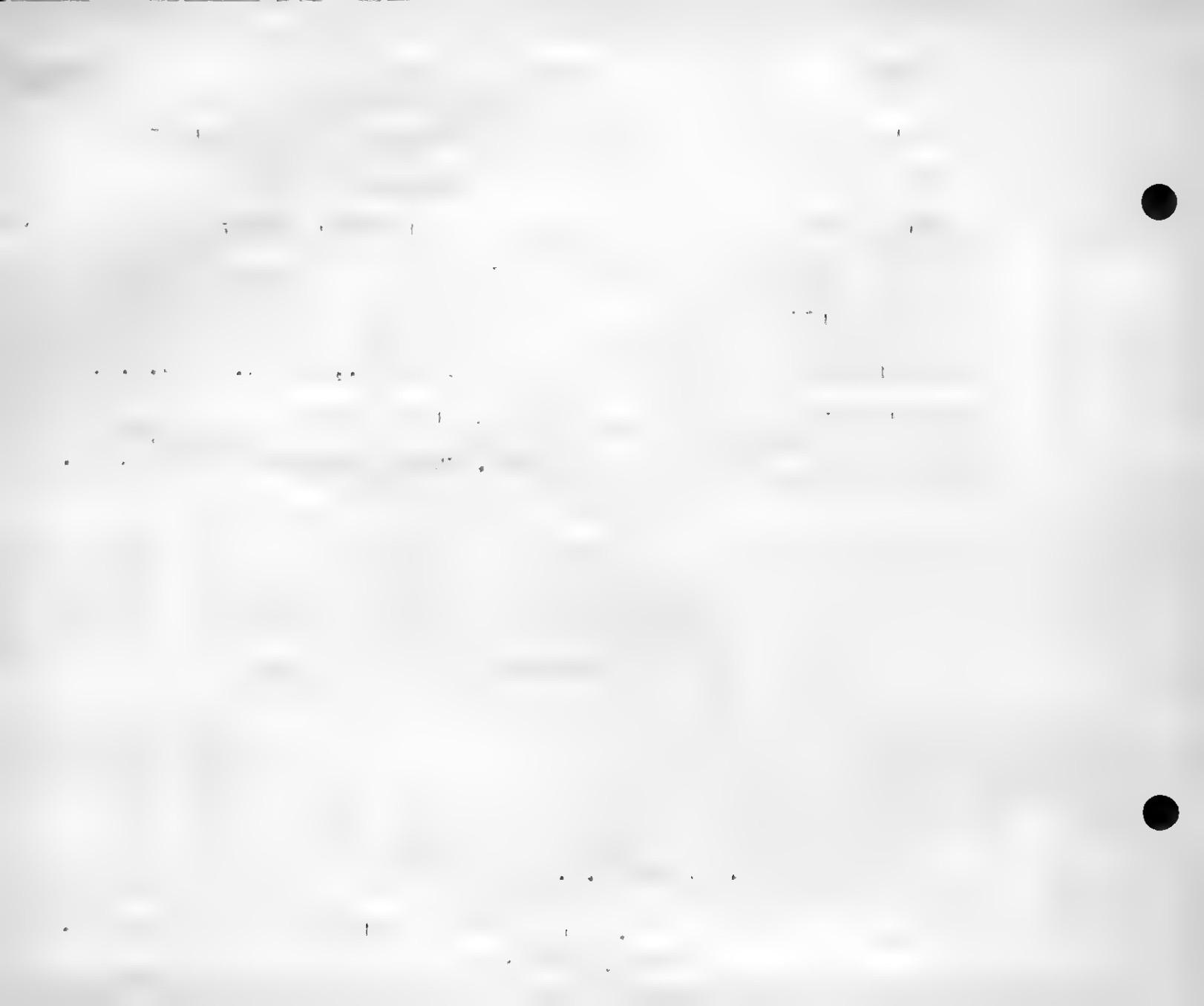
09038

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1 PLACE OF DEATH a. COUNTY Washington MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		< LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reeder Nursing Home			d. STREET ADDRESS 44 N. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Daniel Warvel Emmert		First Daniel	Middle Warvel	Last Emmert	4 DATE OF DEATH June 20, 1966			
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED Never married	8. DATE OF BIRTH April 25, 1870	9. AGE (In years last birthday) 96 yrs.	F UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 25	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Rural Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Leonard Emmert			14. MOTHER'S MAIDEN NAME Sarah Warvel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No.		16. SOCIAL SECURITY NO. 220-44-7521		17. INFORMANT Mrs. Nettie B. Emmert, 44 N. Main St.		Boonsboro, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			<i>Atherosclerotic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) Boonsboro	(County) Washington	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from April 8, 1966 , to June 20, 1966 , that (I) (we) last saw the deceased alive on June 20, 1966 , and that death occurred at 5P.M. from causes and on the date stated above							22b. DATE SIGNED 6/21/66	
22a. SIGNATURE <i>G.W. LeVan</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22b. DATE SIGNED 6/21/66				
22c. PHYSICIAN'S NAME (Type) G.W. LeVan		22d. ADDRESS Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-66		23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUN 24 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

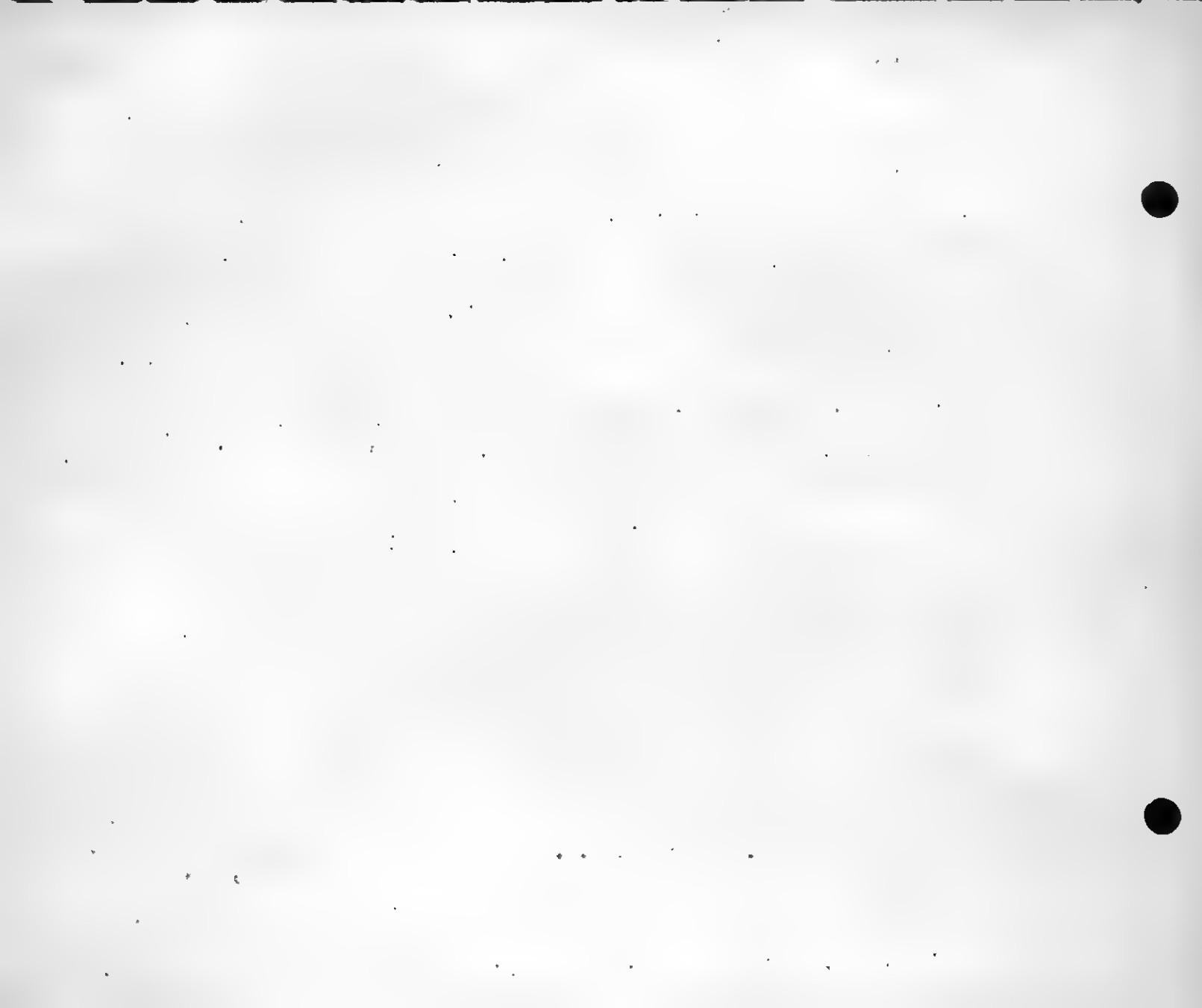




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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Washington MARYLAND				a. STATE Maryland b. COUNTY Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 6 weeks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 28 Gurlinger Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CHURGE	Middle W	Last FOWLER	4. DATE OF DEATH June 8 1966	Month JUNE	Day 8	Year 1966							
5. SEX		6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1 1911	9. AGE (In years last birthday) 55 yrs.	10. UNDER 1 YEAR Months 5	11. UNDER 24 HRS Days 5	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME George C. Fowler Sr.	14. MOTHER'S MAIDEN NAME Virginia Rose	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No	16. SOCIAL SECURITY NO. 217-10-0114	17. INFORMANT 28 Gurlinger Ave. Hagerstown Mabel J. Fowler	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 143X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Hypertrrophic cardiovascular disease DUE TO 11(?) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	INTERVAL BETWEEN ONSET AND DEATH 8 days-
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Washington Co.	(State) Md.	21. I certify that (I) (this hospital) attended the deceased from 1-15, 1966 to 6-8, 1966, that (I) (we) last saw the deceased alive on 6/8 1966, and that death occurred at 8:15 AM, from the causes and on the date stated above.						
22a. SIGNATURE John H. Hornbaker				22b. DATE SIGNED 6:10:66											
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 West Washington St., Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) June 11-66				23b. DATE THEREOF June 11-66	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.									
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.				25a. REC'D BY REGISTRAR JUN 13 1966								25b. REGISTRAR'S SIGNATURE Charles Judge			



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

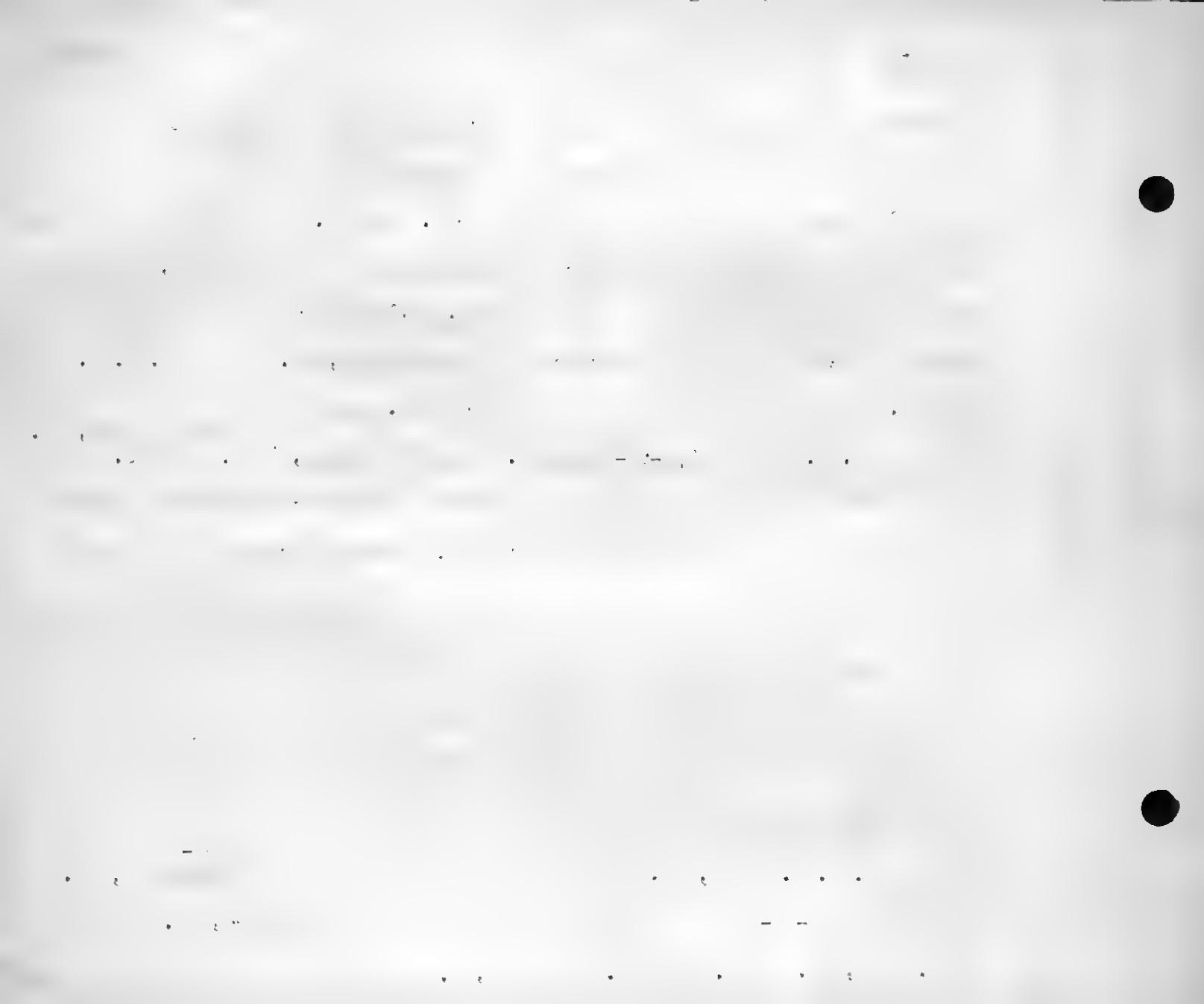
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19042

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 901 Daul Hiway		d. STREET ADDRESS 44 S. Main St.	
3. NAME OF DECEASED (Type or print) Robert		First Robert	Middle Donald
4. DATE OF DEATH Gordon		Last Gordon	Month June 30,
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 16, 1916		9. AGE (in years) 49 (last birthday)	10. IF UNDER 1 YEAR Months 9 Days 14 Hours 00 Min. 00
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) Sales Engineer		10b. KIND OF BUSINESS OR INDUSTRY Metal Industry	11. BIRTHPLACE (State or foreign country) Brownsville, Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Peter B. Gordon	
14. MOTHER'S MAIDEN NAME Nancy H. Horne		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W. W. Two	
16. SOCIAL SECURITY NO. 178-07-0250		17. INFIRMITY Mrs. Ernestine Gordon, 44 S. Main St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fresh Thrombotic Occlusion Of Anterior Descending Instant		INTERVAL BETWEEN ONSET AND DEATH DUE TO Left Coronary Artery	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis, Moderately Severe		Recent	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>E. W. Ditto</i>		22. DATE SIGNED 7-2-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-66	23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		23d. LOCATION (City, town or county) (State) Boonsboro, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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29850

CERTIFICATE OF DEATH

119143

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 58 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 260 S. Mulberry St.		d. STREET ADDRESS 260 S. Mulberry St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Katherine	Middle Pearl	Last Grimes
4. DATE OF DEATH June 6	Month 1966	Doy 19	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. B. DATE OF BIRTH 2/11/88	9. AGE (in years last birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (County & State or foreign country) Georgetown, W. Va.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Butts	14. MOTHER'S MAIDEN NAME Rebecca Kerfoot	Address Hagerstown, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Cecil Grimes	18. INTERVAL BETWEEN INSET AND DEATH 6 days
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		DUE TO 4700	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO 	(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 		(County) 	
		(State) 	
21. I certify that (I) (this hospital) attended the deceased from 3-11 , 19 63 , to death , 19 66 , that (I) (we) lost saw the deceased alive on 6-4-66 , 19 66 , and that death occurred at 11:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert F Keedle		22b. DATE SIGNED 6-7-66	
22c. PHYSICIAN'S NAME (Type) Robert F Keedle		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/8/66	
23c. NAME OF CEMETERY OR CREMATORIAL Shanktown Cemetery		23d. LOCATION (City or Town) (County) (State) rural Clear Spring Md.	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		ADDRESS Hagerstown, Md.	
		25a. REC'D BY REGISTRAR JUN 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CSC51

CERTIFICATE OF DEATH

110044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			b. COUNTY Washington		
c. LENGTH OF STAY IN lb one Year			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 156 S. Potowmack St.			d. STREET ADDRESS 156 S. Potowmack St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT		First LEE	Middle GUESSFORD, JR.	Last JUN	4. DATE OF DEATH Month June
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1902	9. AGE (in years last birthday) 35 yrs	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Hag. Gas Co.	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. City		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Robert L. Guessford			14. MOTHER'S MAIDEN NAME Sarah Jane Everhart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-09-6342	17. INFORMANT Mrs. Cecelia Guessford, 156 S. Potowmack	Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer			INTERVAL BETWEEN ONSET AND DEATH MONTHS		
163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of lung			2 yrs.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/31/66 , 19 66 , to 6/3/66 , 19 66 , that (I) (we) last saw the deceased alive on 6/31/66 , and that death occurred at Hagerstown , M, from causes and on the date stated above.					
22a. SIGNATURE <i>Howard N. Weeks, M.D.</i>		22b. DATE SIGNED 22 Jun 1966			
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.		22d. ADDRESS 385 Northern Avenue Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/66	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, MD	
24. FUNERAL DIRECTOR A. K. Cofflan Funeral Home, Inc.		ADDRESS Hagerstown, MD		25a. REC'D BY REGISTRAR JUN 7 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



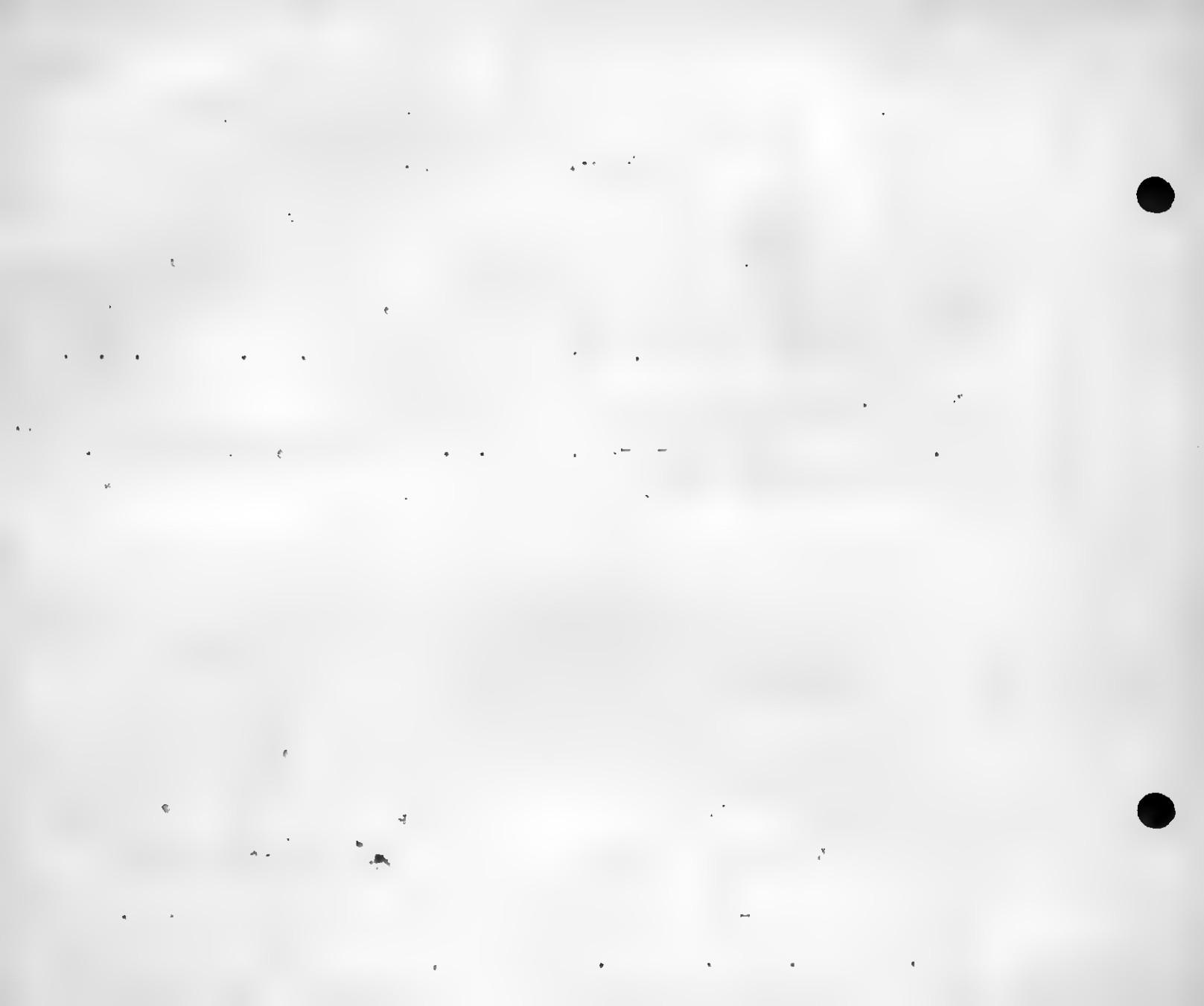
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			b. COUNTY Washington			
c. LENGTH OF STAY IN 1b 46 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Nursing Home			d. STREET ADDRESS 670 Highland Way			
3. NAME OF DECEASED (Type or print) First Anna Middle Elsie Last Hammond			4. DATE OF DEATH Month June 28, Day 19 66			
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 13, 1879 9. AGE (In years last birthday) 86 yrs. 10. IF UNDER 1 YEAR <input type="checkbox"/> 11. IF UNDER 24 HRS. <input type="checkbox"/>			10. IF UNDER 1 YEAR <input type="checkbox"/> 11. IF UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Seamstress			10b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph S. Grimm			14. MOTHER'S MAIDEN NAME Arbelan Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. 214-09-7354A 17. INFORMANT Mrs. R. Wilmer Pearl, 100 Marbern Rd. Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension C/ Disease</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <i>days</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 11-8-66	(County) 1966 (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-8-66 , to 1966 , that (I) (we) last saw the deceased alive on June 28 1966 , and that death occurred at 12 P.M. from the causes and on the date stated above.						
22a. SIGNATURE <i>Robert P. Conrad</i>		22b. DATE SIGNED 6-28-66				
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad		22d. ADDRESS 137 W. Washington Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-1-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rohrersville Cemetery	23d. LOCATION (City, town or county) (State) Rohrersville, Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CSC53 119046
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		c. LENGTH OF STAY IN IB		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Washington MARYLAND				a. STATE Maryland	b. COUNTY Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Samples Manor (Rural)		Samples Manor (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Residence		Chestnut Grove Road			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
CLEMMA (None)		HANES		June 12, 1966	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years at last birthday) IF UNDER 1 YEAR Months Deys Hours Min.
Female White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 2, 1895	70 yrs.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Housewife		Own Home		Samples Manor, d. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Aaron Daugherty		Emma Myers		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT J. Alfred Hanes Address	
No		One		REDA, Harpers Ferry, W. Va. 25425	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO			
(c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1966, to June 12, 1966, that (I) (we) last saw the deceased alive on June 12, 1966, and the death occurred at 10:00 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 6/13/66			
22c. PHYSICIAN'S NAME (Type)		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Bonsuwan, Md.
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery, Samples Manor, Md.		23d. LOCATION (City, town or county) (State)	
23f. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles Eckler, Harpers Ferry, W. Va.		25e. REC'D BY REGISTRAR Date JUN 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

119047

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal to **any event, within 72 hours after death.**

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN b <u>11 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>148 South Locust Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIE</u>		First <u>LILLIE</u>	Middle <u>VIRGINIA</u>
4. DATE OF DEATH <u>June 19, 1966</u>	Month <u>June</u>	Day <u>19</u>	Year <u>1966</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 31, 1891</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		9. AGE (In years last birthday) <u>74 yrs.</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Breastedsville, Wash. Co., Md. USA</u>	
13. FATHER'S NAME <u>George Shunk</u>		12. CITIZEN OF WHAT COUNTRY? <u>Co., Md. USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Rebel Shunk 148 South Mulberry Street</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>160X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>Missed</u>	
(b) DUE TO <u>asthma</u>			
(c) <u>160x metritis</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>near Tilghman, Wash. Co.</u>
20f. (City or town) <u>near Tilghman</u>		(County) <u>Wash. Co.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/19/66</u> to <u>6/19/66</u> , that (I) (we) last saw the deceased alive on <u>6/19/66</u> , and that death occurred at <u>M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Louis L. Shunk</u>		22b. DATE SIGNED <u>6/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis L. Shunk</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <u>580 N. Roxbury</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/31/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Manor Cemetery</u>
23d. LOCATION (City or Town) <u>Near Tilghman, Wash. Co.</u>		(County) <u>Wash. Co.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Anne K. Coffman Funeral Home, Inc.</u>		ADDRESS <u>148 South Locust Street</u>	25a. REC'D BY REGISTRAR <u>JUN 22 1966</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

110048

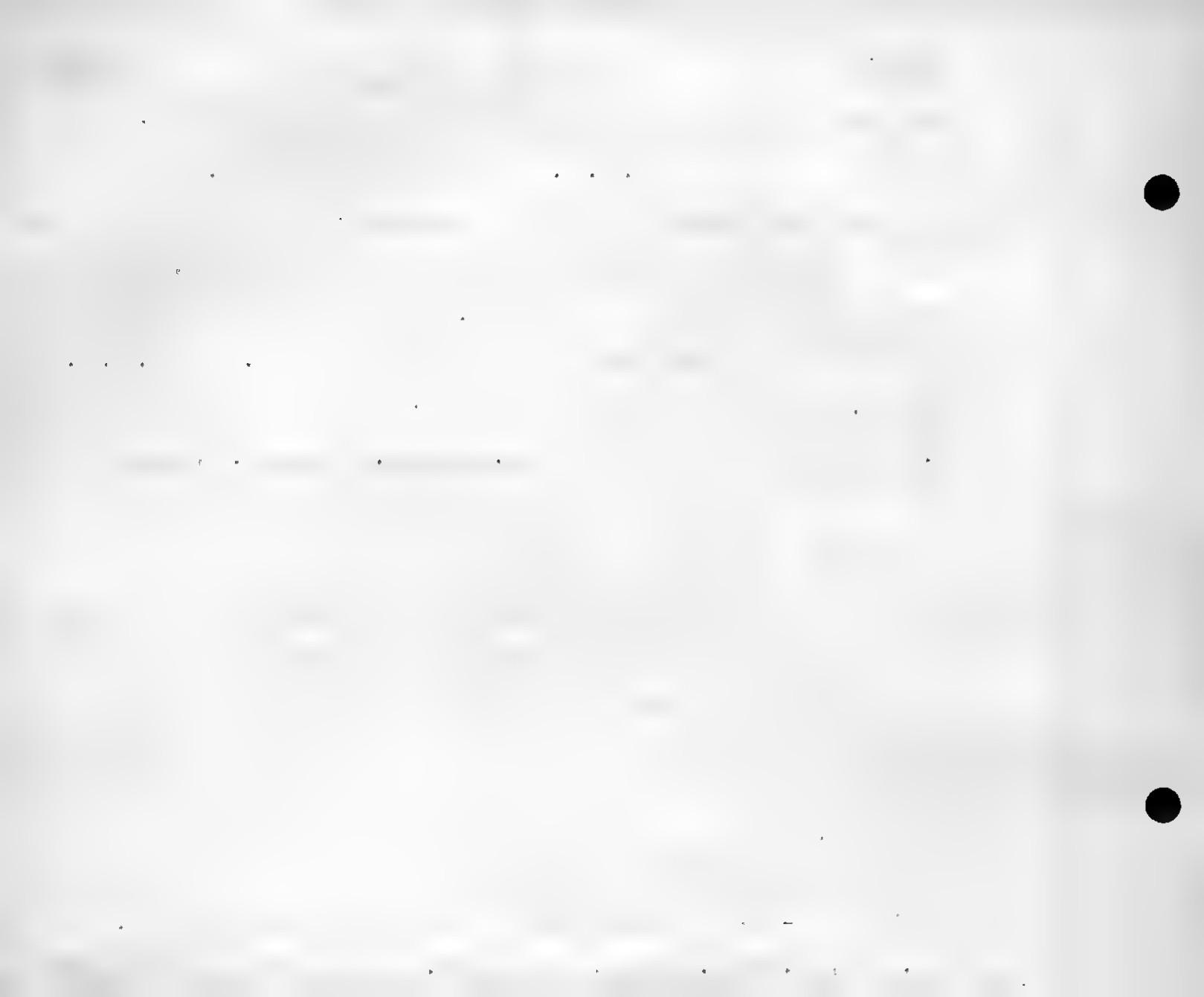
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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OSG55

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb D. O. A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keedysville Rfd. 1		f. STREET ADDRESS Chestnut Grove		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Madeline		First Ellen	Middle Hardy	Lost Hardy	4. DATE OF DEATH June 26,	Month 1966	Day 19	Year 66	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1912	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR 5 months	IF UNDER 24 HRS. 0 days	Hours 0 min	
10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Chestnut Grove, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph F. Bussard		14. MOTHER'S MAIDEN NAME Beulah Holmes		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. George W. Hardy, Rfd. 1, Keedysville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Abortion and complications of		INTERVAL BETWEEN ONSET AND DEATH 6 months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Adenocarcinoma of ovaries		DUE TO 6 months					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) Boonsboro		(County) Washington	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 5-8- , 19 66 , to 6-26- , 19 66 , that (I) (we) last saw the deceased alive on 6-26- , 19 66 , and that death occurred at M , from causes and on the date stated above.						22b. DATE SIGNED 6-27-66			
22c. PHYSICIAN'S NAME (Type) JOSEPH F. SECONDARI		22d. ADDRESS Boonsboro Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-29-66		23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery		23d. LOCATION (City or Town) Samples Manor, Md.		(County) Washington	(State) Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS 		25a. REC'D BY REGISTRAR JUL 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00056		119049	
1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1B 21 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CLEARVIEW NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First STELLA	Middle VALENTINE	Last HARNER
4. DATE OF DEATH	JUNE	Month	Day Year 5 19 66
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN VALENTINE		14. MOTHER'S MAIDEN NAME SARAH (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 064-07-5878	
17. INFORMANT MR. WOODROW HARNER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coma - cerebral arteriosclerosis		31-5	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 6-2-66	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2-66 to 6-5- , 19 66 , that (I) (we) last saw the deceased alive on 6-2-66 , and that death occurred at H.A. M, from the causes and on the date stated above.		22b. DATE SIGNED 6/6/1966	
22a. SIGNATURE John C. Morton M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JOHN C. MORTON M.D.		22d. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 7, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. JOHN's LUTHERAN CEM.		23d. LOCATION (City, town or county) (State) LITTLESTOWN, PENNSYLVANIA	
24. FUNERAL DIRECTOR CHARLES M. ROUZER		25a. REC'D BY REGISTRAR JUN 9 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

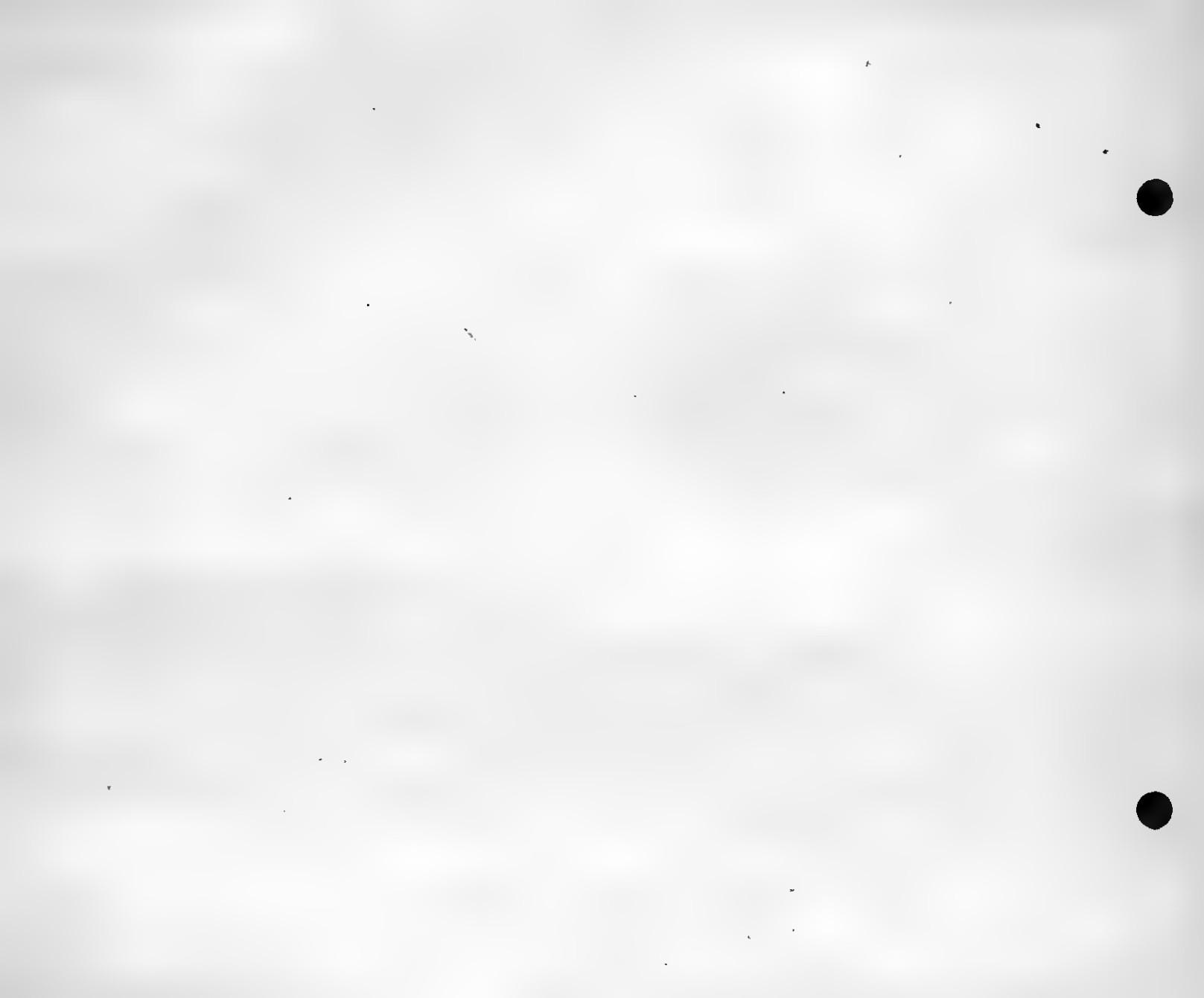
CERTIFICATE OF DEATH

09050

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 M		2957	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY		Wash.	a. STATE	Pa.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Waynesboro	b. COUNTY	Franklin
c. LENGTH OF STAY IN 1b		—		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Wash. Co. Hospital		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First: Carrie Middle: Viola Last: Hartman	4. DATE OF DEATH	Month: June Day: 27 Year: 1966
5. SEX		6. COLOR DR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
m		w	WIDDWEO <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	9. AGE (In years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housekeeper		Hairine	Waynesboro, Pa.	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Jacob E. Hartman		Katie Stauffer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		—	Informant	ROB
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Mustier Pulmonary Infarct		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)		
		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Hansen pneumonia of Colon		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19		19		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above.				
22a. SIGNATURE		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS	
			Greencastle, Pa.	
23a. BURIAL, Cremation, Removal (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county) (State)
		6/30/66	Prices Cemetery	Franklin Co., Pa.
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		J. E. Monach - Greencastle, Pa.	JUN 30 1966	Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

29658

CERTIFICATE OF DEATH

09051

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland b. COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN lb 13 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e HAGERSTOWN	
3 NAME OF DECEASED (Type or print) IRVIN (NNN) HERB		f STREET ADDRESS 821 So. Mont Valla Ave	
4 DATE OF DEATH June 13 1966		Month Day Year	
S. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 25 1890
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years 76 months yrs)
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Force Inspector		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Pitt Cannel Northumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Herb		14. MOTHER'S MAIDEN NAME Caroline Ruever	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 100-09-7373	
17. INFORMANT Mrs Olivia C. Herb		Address Ave 821 So. Mont Valla	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks.	
DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis			
(c)		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-25, 1966, to 6-13, 1966, that (I) (we) last saw the deceased alive on 6-13 1966, and that death occurred at 8:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE Robert P. Conrad		22b. DATE SIGNED 6-13-66	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad		22d. ADDRESS 137 W. Washington Hagerstown 774	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/14/66	
23c. NAME OF CEMETERY OR CREMATORY Francis F. Seidel Crematory		23d. LOCATION (City or Town) (County) (State) Reading, Berks Penna.	
24. FUNERAL DIRECTOR Andrew K. Coffian Funeral Home Inc. Hagerstown, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR JUN 14 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and many event within 72 hours after death.

Item 18 Film G378 6/20/66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 18 Film G378 6/20/66 mh MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington				
c. LENGTH OF STAY IN b. 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1170 Corbett St.		d. STREET ADDRESS 1170 Corbett St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Bridget	First Josephine	Middle Heyworth	4. DATE OF DEATH Month June 10, Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 9, 1925			
9. AGE (In years last birthday) 41 yrs	10. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Rodgers		14. MOTHER'S MAIDEN NAME Josephine Cuminsky				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service Unknown		16. SOCIAL SECURITY NO 213-21-9437				
17. INFORMANT Vincent Heyworth		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty degeneration of liver with advanced portal cirrhosis.		INTERVAL BETWEEN ONSET AND DEATH unknown				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5810						
(b) DUE TO Physical/						
(c) DUE TO Physical/						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown Wash. Co.	20f. (City or town) Hagerstown	(County) Wash. Co.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 66	23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown	(County) Wash. Co.	(State) Md.
24. FUNERAL DIRECTOR <i>Edward W. Thompson</i>		ADDRESS Clear Spring, Md.		25a. REC'D BY REGISTRAR JUN 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15ME (5) 6M 1/66						



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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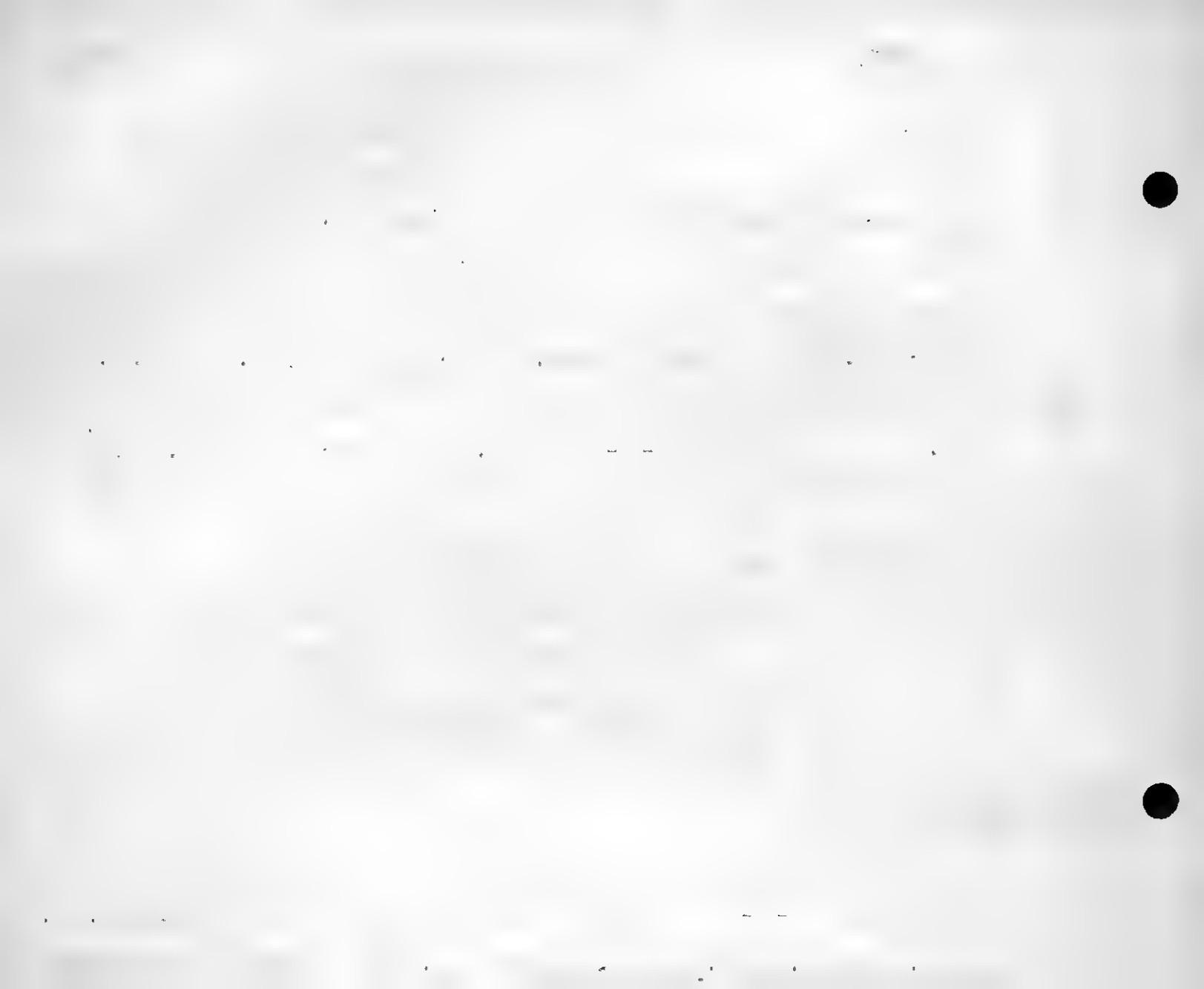
09053

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN b. 11 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First Joseph	Middle Cephus	Last Holmes	4 DATE OF DEATH Month June 5,	Day Year 19 66			
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 24, 1886	9 AGE (In years last birthday) 80 yrs	10 IF UNDER 1 YEAR Months 2	11 IF UNDER 24 HRS Days 11	Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Ret.			10b KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.			11 BIRTHPLACE (County & State, or foreign country) Chestnut Grove, Md.		
13. FATHER'S NAME Clay Holmes			14. MOTHER'S MAIDEN NAME Margaret Bussard			12 CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. 220-10-3835			17. INFORMANT Address Mrs. Addie Webber, 51 Main St. Keedysville, Md.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 552X			<i>Cerebral thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH 2 m. a.m.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {			(b) <i>Generalized arteriosclerosis</i>			Years 7 years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cholelithiasis</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-15-1962 to 6-5-1966 , that (I) (we) last saw the deceased alive on 6-5-1966 , and that death occurred of 7+8 M , from causes and on the date stated above.								
22a. SIGNATURE <i>Joseph Secondari</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6-6-1966		
22c. PHYSICIAN'S NAME (Type) JOSEPH . SECONDARI			22d. ADDRESS Boonsboro Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-8-66		23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Samples Manor, Wash. Md.		
24 FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Ms.		ADDRESS DUN 9		25a. REC'D BY REGISTRAR JUN 9 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



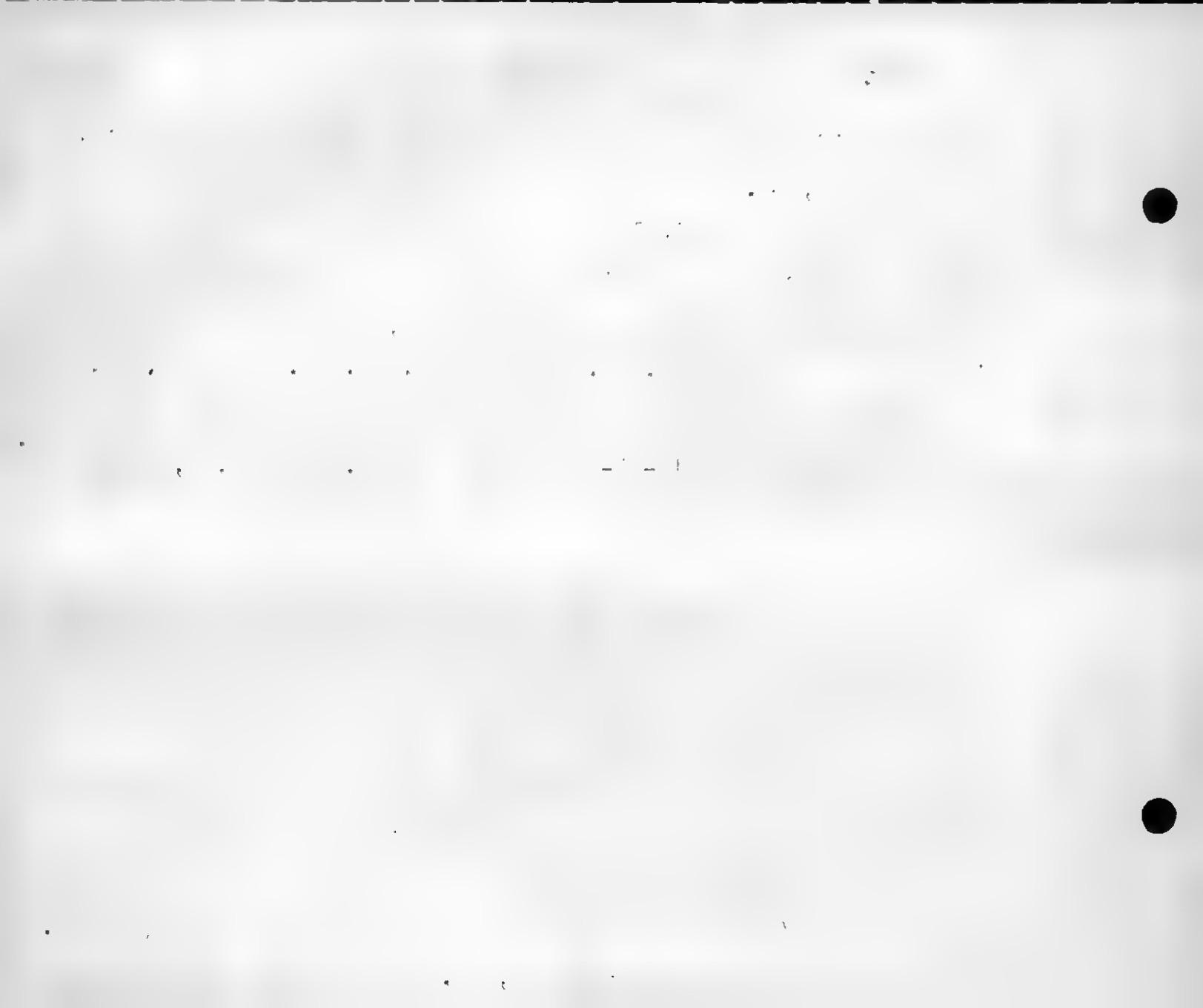
MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH 1. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d. STREET ADDRESS Rural 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Walter	Middle David	Last Hose	4. DATE OF DEATH June	Month	Doy	Year 24 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED # <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1898	9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. US OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Wash. Co. Roads		11. BIRTHPLACE (County & State, or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Edward Hose		14. MOTHER'S MAIDEN NAME Alice Jane Ruebeck		Address Mrs Mary M. Hose Rd. 1, Clear Spring		Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO. 213-24-8620		17. INFORMANT Mrs Mary M. Hose		INTERVAL BETWEEN ONSET AND DEATH Weeks	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure		DUE TO Arteriosclerotic Heart Disease		DUE TO Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4200		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred while at work					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. June 24, 1966		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 22, 1966 , to June 24, 1966 , that (I) (we) last saw the deceased alive on June 23, 1966 , and that death occurred at 9 M, from causes and on the date stated above.							
22a. SIGNATURE Charles C Spencer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-25-66	
22c. PHYSICIAN'S NAME (Type) Charles C Spencer		22d. ADDRESS 145 S. Prospect, Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mennonite Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.	
24. FUNERAL DIRECTOR Margaret Rawland		25a. REC'D BY REGISTRAR JUN 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

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09055

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Williamsport		c. LENGTH OF STAY IN lb 10 years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rd # 1		e. STREET ADDRESS Rd # 1		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM PRESTON JACOBS		4. DATE OF DEATH June 7 1966	Month Doy Year	
S SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/26/05	
9. AGE (In years last birthday) yrs 60		10. KIND OF BUSINESS OR INDUSTRY shoe mfg.	11. BIRTHPLACE (County & State, or foreign country) Tilmington, Md.	
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME William Jacobs		14. MOTHER'S MAIDEN NAME Annie Showe		
15. IS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO. 214-09-5716	17. INFORMANT Mrs. Thelma Jacobs Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction- +201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour Elevating Heart Disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-12, 1943, to 6/13/66, and that (I) (we) last saw the deceased alive on 6/3/1966, and that death occurred at 7:30 P.M. from causes and on the date stated above.				
22a. SIGNATURE John H. Hombaker, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-8-66	
22c. PHYSICIAN'S NAME (Type) John H. Hombaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/66	23c. NAME OF CEMETERY OR CREMATORIAL rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR JUN 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 7/66				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1

1. PLACE OF DEATH a. COUNTY <i>Washington Co. Md.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>WASH</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Co. Hosp</i>		e. STREET ADDRESS <i>Hugh Street</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Baby boy</i>	Middle <i>George</i>	Last <i>Kenneth</i>	4. DATE OF DEATH	Month <i>June</i>	Day <i>1</i>	Year <i>1966</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 6, 1966</i>	9. AGE (In years lost birthday) yrs. <i>1 month</i>	IF UNDER 1 YEAR Months <i>1</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash. Co. Hosp</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Cecil Wenzel Kenneth</i>		14. MOTHER'S MAIDEN NAME <i>Helon Eva Volp</i>		Address <i>Hospital chmrt & Birth certificat</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Hospital chmrt & Birth certificat</i>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia & emphysema, Anemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		Month June	Day 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I attended the deceased from <i>June 6, 1966, to</i> , 19, that I last saw the deceased alive on <i>June 6, 1966</i> , and that death occurred at <i>11:55 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>—</i>	DATE SIGNED <i>6/1/66</i>
ACTUAL SIGNATURE <i>H. N. Weeks</i>		M.D. <i>550 North St. M. H. H. H. 1966</i>							
PHYSICIAN'S NAME (Type) <i>H. N. Weeks</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 14, 1966</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington County Hospital</i>		22d. LOCATION (City, town, or county) <i>Hagerstown, Md.</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. Charles J. Adams</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>JUN 17 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

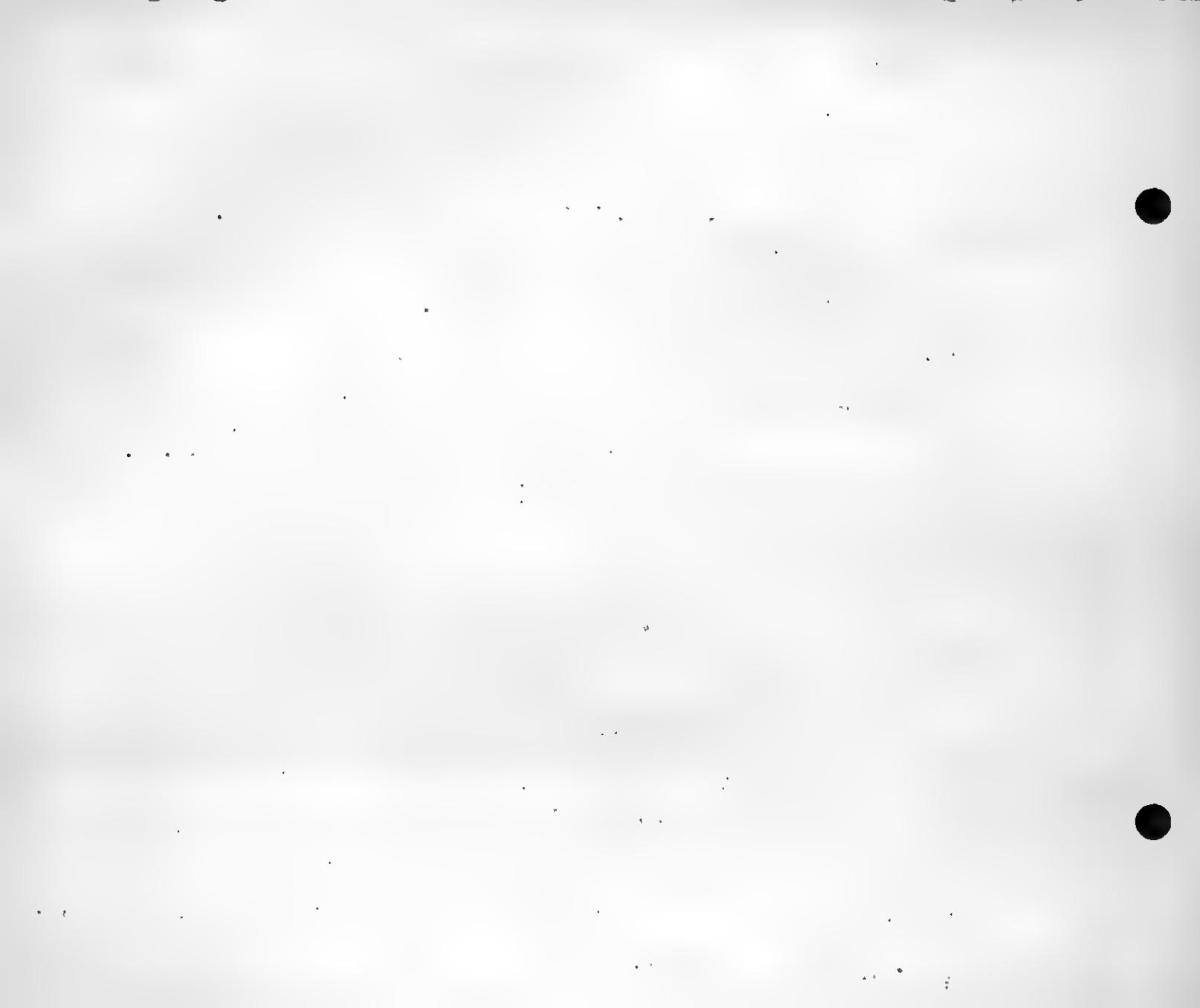
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09064 09057

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reeder's Nursing Home, 141 S. Main			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Archie	Middle (nmi)	Last Leavy	4. DATE OF DEATH June 30th 1966	Day Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 15 Feb. 1896	9. AGE (in years last birthday) 67 yrs.	10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tailor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Leeds, England	
13. FATHER'S NAME Samuel L. Leavy			14. MOTHER'S MAIDEN NAME Leah Stroll		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 157-16-9646		17. INFORMANT Philip Grimes Martinsburg, W.Va. Address 614 West King Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH 10 yrs 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Boonsboro	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 10, 1966</i> , to <i>June 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 30, 1966</i> , and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE <i>G. W. Leaven</i>			22b. DATE SIGNED <i>July 1, 1966</i>		
22c. PHYSICIAN'S NAME (Type) G. W. Leaven		22d. ADDRESS Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal		23b. DATE THEREOF 7/4/66		23c. NAME OF CEMETERY OR CREMATORIUM Beth Jacob	
24. FUNERAL DIRECTOR John H. Bart Jr.		ADDRESS Boonsboro, Md.		25a. REC'D BY REGISTRAR DATE JUL 5 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

25865

CERTIFICATE OF DEATH

191059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-tranit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived, if instit or Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#5			c. LENGTH OF STAY IN 1b 31 years		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#5			d. STREET ADDRESS Leitersburg, Pike		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leitersburg Pike			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLAGGETT BISHOP		First BISHOP	Middle LUNG	Last CLAGGETT	4. DATE OF DEATH Month June Day 5 Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 83 (In years lost birthday) yrs.	9. AGE (In years lost birthday) yrs. 83	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State or foreign country) John Lung, R # 5, Hagerstown, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Lung			14. MOTHER'S MAIDEN NAME Amelia Bishop		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-4750	17. INFORMANT John Lung, R # 5, Hagerstown, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>Arteriosclerotic Heart Disease</i> 5 mo. Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Arteriosclerosis</i> 10 yrs (c) <i>Generalized Arteriosclerosis</i> 15 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Leitersburg, Pike	(County) (State) Washington, D.C.
21. I certify that (I) (this hospital) attended the deceased from 11-11-57 , 19 to 6-5-66 , 19, that (I) (we) last saw the deceased alive on 3-29-66 , 19, and that death occurred at 11:30 A.M. from causes and on the date stated above.					
22o. SIGNATURE <i>John C. Morton</i>					
22c. PHYSICIAN'S NAME (Type) <i>John C. Morton</i>		22d. DATE SIGNED 6/6/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery	23d. LOCATION (City or Town) (County) (State) Leitersburg, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		ADDRESS Hagerstown, Maryland		25a. REC'D BY REGISTRAR JUN 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (42) 20 M 1/66					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09059

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown Maryland

MARYLAND

c. LENGTH OF STAY IN 1b

35 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Clarence Florence

5. SEX

6. COLOR OR RACE

Male

Colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Mar 7 1910

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

10b. KIND OF BUSINESS OR INDUSTRY

Pangborn Corp.

11. BIRTHPLACE (County & State, or foreign country)

Lincoln, Ga.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

Joe C. Hawes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank, date of service

no

16. SOCIAL SECURITY NO. 17. INFORMANT

225-09-8176

Mrs. Willie Jenkins Green Wood, S.C.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DO TO

(b)

Cirrhosis of liver & Hemorrhage

from Esophageal varices

Anemia - Secondary

DO TO

(c)

DO TO

INTERVAL BETWEEN
ONSET AND DEATH

4 days

4 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

May 16 1966, to June 13, 1966

21. I certify that (I) (this hospital) attended the deceased from May 16, 1966, to June 13, 1966, and that death occurred at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Philip J. Hirshman

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
6/17/66

22c. PHYSICIAN'S NAME (Type)

PHILLIP J. HIRSHMAN, M.D.

22d. ADDRESS

159 W. WASHINGTON ST., HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 6-18-66

23b. DATE THEREOF

Ebenezer Cemetery

23d. LOCATION (City, town or county)

Lincolnton Ga.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John R Watson Jr Hagerstown Md.

ADDRESS

25a. REC'D BY REGISTRAR

JUN 20 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge



1 M

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

08067

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 55 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MD. STATE HOSPITAL				d. STREET ADDRESS 553 FREDERICK ST.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First GOLDIE	Middle MARGARET	Last MARTIN	4. DATE OF DEATH JUNE 11 1966	Month JUNE	Day 11	Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1893	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY PALMER				14. MOTHER'S MAIDEN NAME LAURA ELLEN FARSH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. GUYD. MARTIN		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CARCINOMA OF UTERUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS - HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (the hospital) attended the deceased from 6-1-1966 to 6-11-1966 , that (I) (we) last saw the deceased alive on 6-11-1966 , and that death occurred at 1130 M. from the causes and on the date stated above.								22b. DATE SIGNED 6-11-66
22a. SIGNATURE Antonio U. Pallagrosi				22b. ADDRESS 1500 Penna Ave Hagerstown				
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAROSI		23. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) BURIAL 23b. DATE THEREOF 6/14/66 23c. LOCATION (City, town or county) (State) HAGERSTOWN MD.						
24. FUNERAL DIRECTOR W. J. Norman, Hagerstown, Md.				25a. REG'D BY REGISTRAR JUN 16 1966 25b. REGISTRAR'S SIGNATURE Charles Judge				



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FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09061

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
WASHINGTON MARYLAND		MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE	
c. LENGTH OF STAY IN 1b 1 YR.		d. STREET ADDRESS MAIN STREET & SHOWALTER ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAIN STREET & SHOWALTER ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH FRANCIS McCARTHY JR.		4. DATE OF DEATH JUNE 30 19 66	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 2, 1920	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) 46 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P.A.		10b. KIND OF BUSINESS OR INDUSTRY MACK TRUCKS	
11. BIRTHPLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH F. McCARTHY SR.		14. MOTHER'S MAIDEN NAME MARY McKENNA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 17. INFORMANT 1415 LIBRARY AVENUE W.W. II 119-22-9865 MRS. MARGARET McCARTHY JR. McKEESPORT, PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH FW MINUTES	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		SUBINTIMAL HEMORRHAGE AND THROMBOTIC OCCLUSION	
Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause first. (b)		OF ANTERIOR DESCENDING BRANCH OF LEFT CORONARY ARTERY, FRESH	
DUE TO (c)		CORONARY ATHEROSCLEROSIS, SEVERE	
DUE TO		SEVERAL YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE 		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO JR. M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 6/30/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF JUNE 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM NEW ST. JOSEPHS CEM.		23d. LOCATION (City, town or county) (State) E. McKEESPORT, PENNSYLVANIA	
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL 5 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

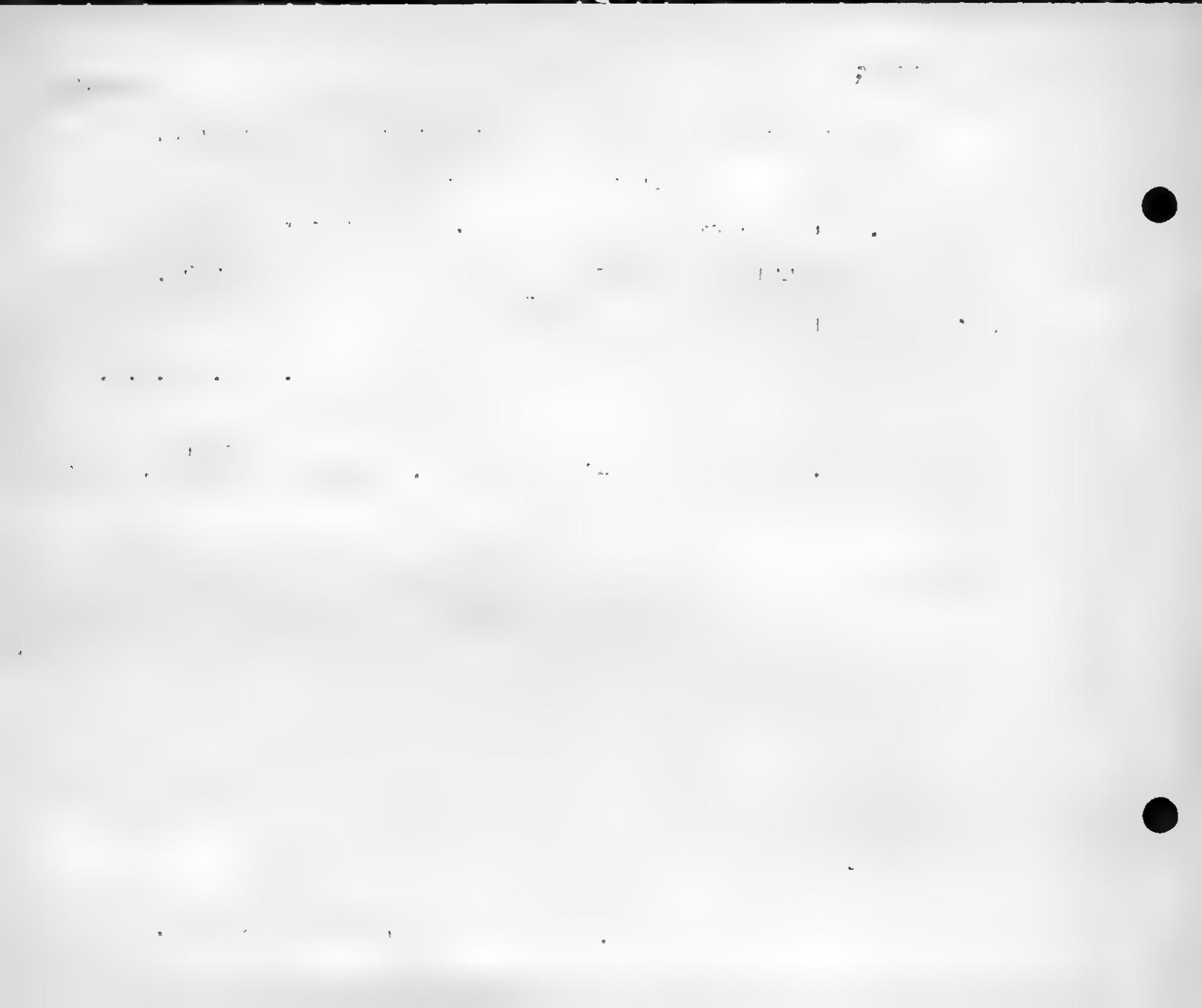


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

CERTIFICATE OF DEATH						119062						
1. PLACE OF DEATH a. COUNTY WASHINGTON			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND			b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK			< LENGTH OF STAY IN lb LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK			d. STREET ADDRESS W. MAIN STREET			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME W. MAIN STREET									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First WILLIAM		Middle LEE		Last MCCARTHY		4 DATE OF DEATH	Month JUNE 30,	Day 19	Year 66	
S. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/22/1905	9 AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min		
10a. US-AL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEVI MCCARTHY						14. MOTHER'S MAIDEN NAME IDA BELLE MYERS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			16. SOCIAL SECURITY NO W.W. 2 219-05-1079			17. INFORMANT JACOB E. McCARTY			Address BLUE HILL HANCOCK, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH inner
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						Coronary artery disease						5 yrs
DUE TO (b)						Chronic Pulmonary Obstruction Disease						10 yrs
DUE TO (c)												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/19/61 , 19, to 5/6/66 , 19, that (I) (we) last saw the deceased alive on 5/6/66 , 19, and that death occurred at 11:30A M, from causes and on the date stated above.												
22a. SIGNATURE F B Thomas M.D.			M.D. ATTENDING PHYS <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7/2/66
22c. PHYSICIAN'S NAME (Type) F B Thomas			22d. ADDRESS HANCOCK, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF JULY 4, 1966			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. PETERS CATHOLIC			23d. LOCATION (City or Town) (County) (State) HANCOCK, WASH. MARYLAND			
24. FUNERAL DIRECTOR Howard & Helen Hancock Md									25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE
									DATE JULY 6 1966			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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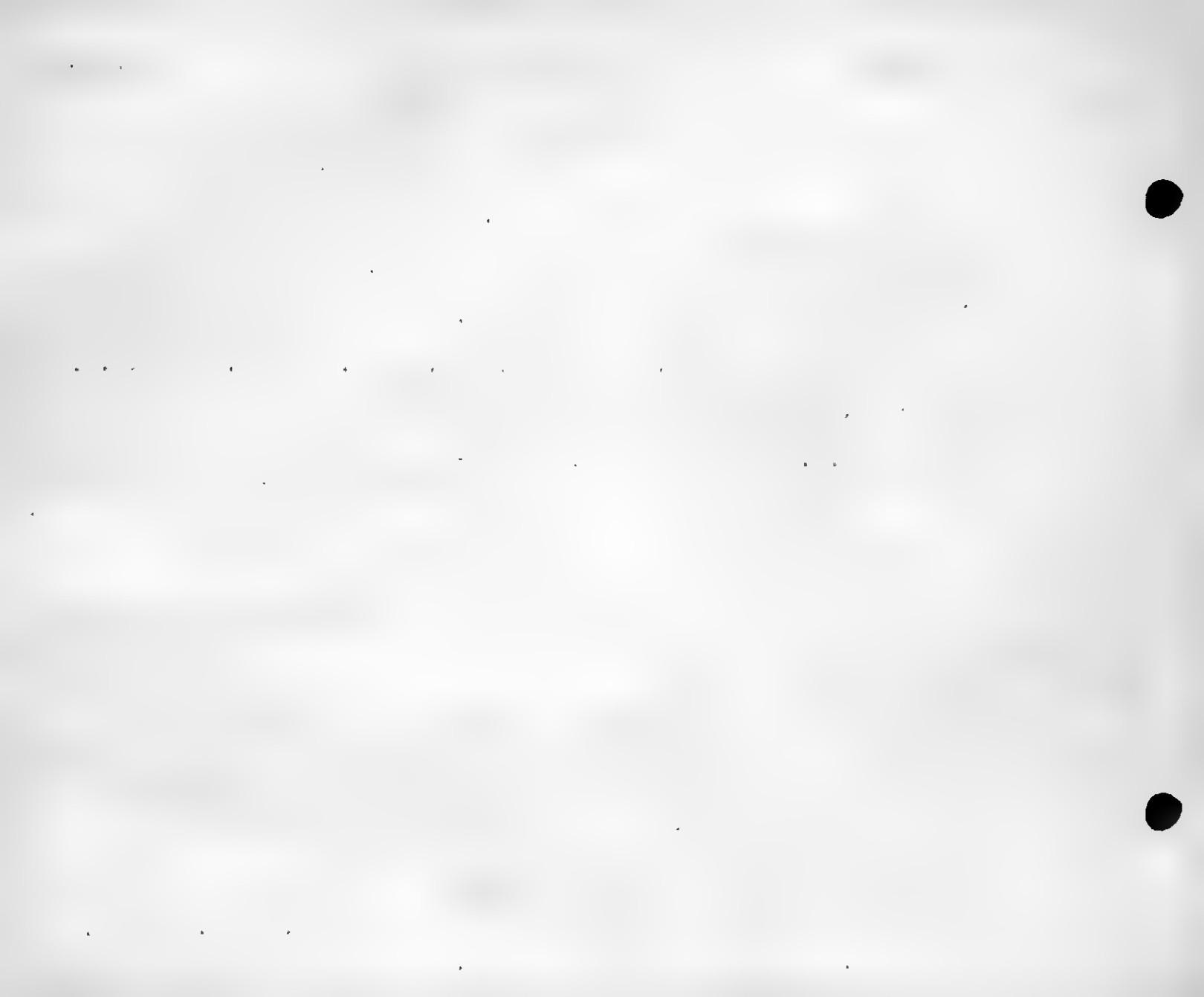
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CERTIFICATE OF DEATH

09063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington Maryland		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
f. STREET ADDRESS 117 King Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First LUTHER	Middle SILPSON	Last LIDDLEKAUFF	
4 DATE OF DEATH	June 30, 1966	Month	Day Year	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Dec. 13, 1846	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (in years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY H. Auto Parts		
11 BIRTHPLACE (County & State, or foreign country) H. G. Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Martin L. Middlekauff		14. MOTHER'S MAIDEN NAME Elizabeth Simpson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Yes		16. SOCIAL SECURITY NO. 500-38-8327		
17. INFORMANT Miss Irene Middlekauff		Address 147 King Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH 7 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphosarcoma of Nasal Pharynx</u> (c) <u>6 mos</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>30 June 1966</u> , to <u>29 June 1966</u> , that (I) (we) last saw the deceased alive on <u>30 June 1966</u> and that death occurred at <u>1 PM</u> , from causes and on the date stated above.				22b. DATE SIGNED 7/1/66
22a. SIGNATURE <u>J. Wilson</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/66	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) H. G. Wash. Co. Md.
24. FUNERAL DIRECTOR Harvey X. Coffman Funeral Home, Inc.		ADDRESS Hagerstown, Maryland	25a. REC'D BY REGISTRAR DATE JUL 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH											
1 05071				09064																			
1. PLACE OF DEATH a. COUNTY WASHINGTON				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE MARYLAND				b. COUNTY WASHINGTON											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 60 YRS.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL								d. STREET ADDRESS TOWNEHOUSE MANOR				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
750 DUAL HIGHWAY								750 DUAL HIGHWAY															
3. NAME OF DECEASED (Type or print) LEWIS AVENON MILLER				First Middle Last				4. DATE OF DEATH JUNE 24 1966				Month Day Year											
5. SEX MALE				6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH NOV. 16, 1903				9. AGE (In years last birthday) 62 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL PLANNER				10b. KIND OF BUSINESS OR INDUSTRY AIR-CRAFT MFG.				11. BIRTHPLACE (County & State, or foreign country) VENANGO CO., PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME ABEL A. MILLER								14. MOTHER'S MAIDEN NAME EMMA F. KUGLER															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-09-6948 HA				17. INFORMANT MADELINE K. MILLER HAGERSTOWN, MARYLAND				TOWNEHOUSE MANOR APT. 104											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] & PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)				DUE TO				Carcinomatosis Carcinoma of Prostate				INTERVAL BETWEEN ONSET AND DEATH 6 mos											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Esco-Colonic Fistula, Secondary Anemia												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>June 24, 1966</u> , and that death occurred at <u>Hagerstown</u> , M, from the causes and on the date stated above.								22a. SIGNATURE JACK H. REACHLEY M.D.				22b. DATE SIGNED 6/27/1966											
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 221 W. WASH. ST. HAGERSTOWN, MARYLAND				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/27/1966				23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY				23d. LOCATION (City, town or county) HAGERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR CHARLES M. ROUZER				ADDRESS HAGERSTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE JUN 29 1966				25b. REGISTRAR'S SIGNATURE Charles Judge											
VR A15 (4) 20M 1/65																							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09065

09072

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		b. COUNTY Washington	
c. LENGTH OF STAY IN 16 Office visit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 145 S. Prospect St.		d. STREET ADDRESS 846 Spruce St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elmer	First Frank	Middle Mills	Last June
4. DATE OF DEATH 15, 1966	Month June	Doy 15	Year 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> #	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 9/18/01		9. AGE (In years last birthday) 64 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gaurd		11. BIRTHPLACE (County & State or foreign country) Indian Springs, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Elmer Mills		14. MOTHER'S MAIDEN NAME Alice Virginia Drury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. 220-16-2032	
17. INFORMANT Mrs Athalee Mills		18. ADDRESS 846 Spruce St. Hagerstown, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH 1 days	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b) Myocardial infarction		DUE TO 2 hours	
(c) Arryothroto heart disease		DUE TO 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15 , 1966, to June 15 , 1966, that (I) (we) last saw the deceased alive on June 15, 1966 , and that death occurred at 3:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edmund Moody		22b. DATE SIGNED June 15, 1966	
22c. PHYSICIAN'S NAME (Type) Charles J. Moody		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Peters Luthern		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.	
24. FUNERAL DIRECTOR Margaret Rawlson		25d. REC'D BY REGISTRAR JUN 20 1966	
		25e. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09066

1
M
CSC73
1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 16

6 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Morgan

RALPH

EMERSON

4. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

March 12, 1909

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Rural, Farmer

10b. KIND OF BUSINESS OR INDUSTRY

own gen. farm

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A?

13. FATHER'S NAME

Irving R. Morgan

14. MOTHER'S MAIDEN NAME

Iva Mae Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or dates of service)

yes

W.W. # 1

212-14-0000 Ralph W. Morgan, Smithsburg, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

491X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Inhalation of tobacco smoke & alcoholism

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19 20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....
saw the deceased alive on..... June 12, 1966, and that death occurred at 5:30A.M. from the causes and on the date stated above.

22a. SIGNATURE

Edson B. Moody

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Edson B. Moody

22d. ADDRESS

145 S. Prospect, Hagerstown, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
Burial June 15, 1966 St. Mark's Lutheran Wolfsville, Fred.co.Md.

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Paul F. Bittle, Myersville,

ADDRESS

25a. REC'D BY REGISTRAR

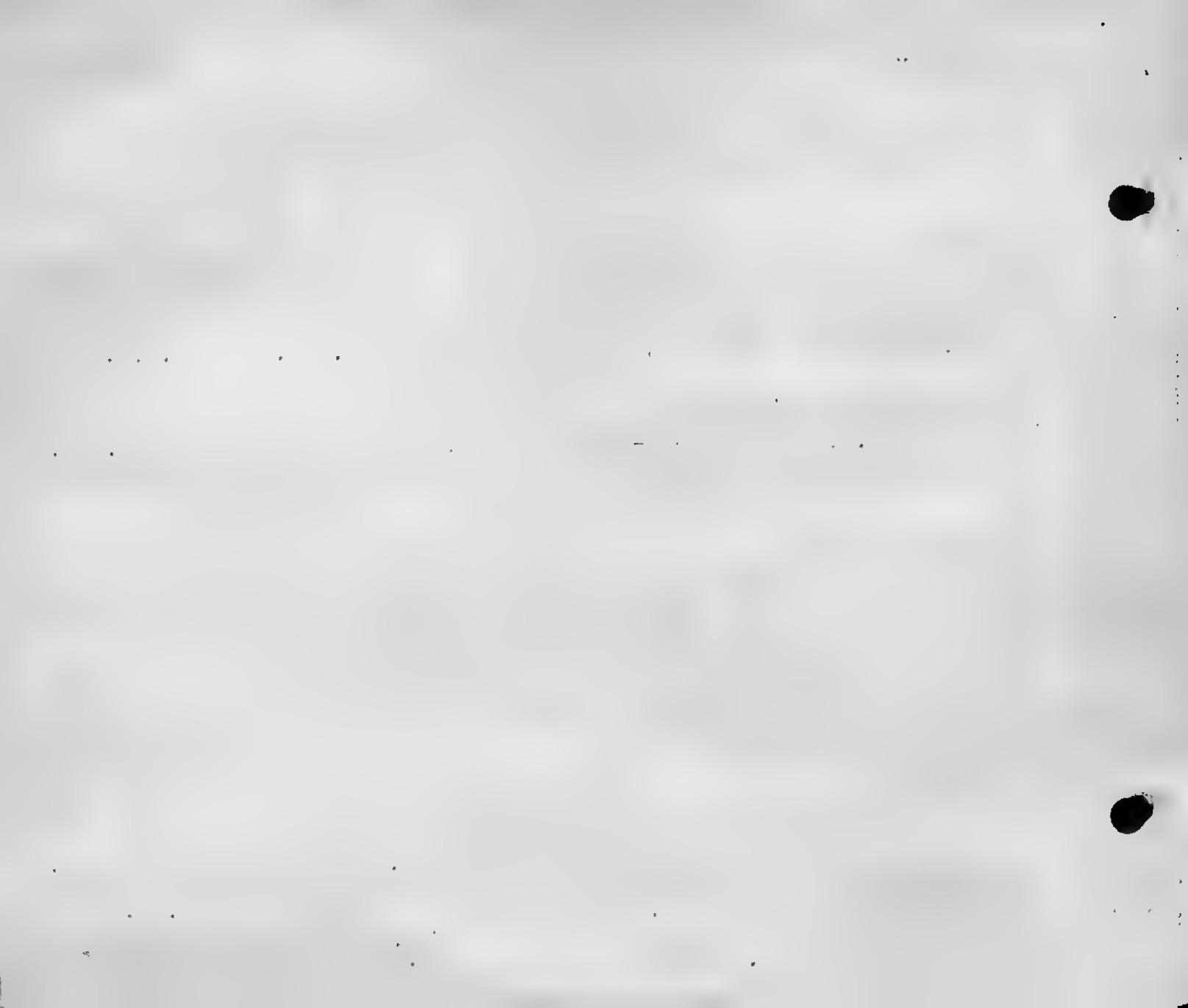
25b. REGISTRAR'S SIGNATURE

JUN 15 1966 Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

22076

CERTIFICATE OF DEATH

09067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Williamsport	c. LENGTH OF STAY IN 16 1 hour	c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Downsville Pike		d. STREET ADDRESS 229 Woodpoint Ave.			
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARL EDWARD MOSE	First Middle Last	4. DATE OF DEATH June 24 1966	Month Day Year		
5. SEX male white	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/98	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) carman		10b. KIND OF BUSINESS OR INDUSTRY railroad	11. BIRTHPLACE (County & State, or foreign country) Sharpsburg, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Mose		14. MOTHER'S MAIDEN NAME Aggie M. Grove			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Terry Mose	Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlu</i> - due general turned 7/4/01 DUE TO (b) <i>Arteriosclerosis and coronary athro-</i> 15-20 yrs stating the underlying cause lost (c) <i>Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Prostate hypertrophy, Benign</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>Aug 1, 1964</i> , to <i>June 24, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 27 1966</i> , and that death occurred at <i>942</i> M, fram causes and on the date stated above.					
22a. SIGNATURE <i>Edward W. Ditto III</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>6-25-66</i>		
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.		22d. ADDRESS 217 W. Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/27/66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Mem. Gard.	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
MINNICH FUNERAL HOME		Hagerstown, Md.	JUN 28 1966		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
Item No. 1116-35673 Date 6/16/66 mb No. 09068														
1. PLACE OF DEATH a. COUNTY		Washington MARYLAND			6/16/66		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Infirmary			b. STATE Maryland		b. COUNTY Washington							
c. LENGTH OF STAY IN 1b		Infirmary			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Sharpsburg, Md.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Antietam			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?							
3. NAME OF DECEASED (Type or print)		First John	Middle William	Last Myers	4. DATE OF DEATH	Month June	Day 11	Year 1966	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	Months 64 yrs.	Days	Hours	Min.			
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1920. 3 1901	64 yrs.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Street metal worker			Air Craft			Maryland			U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME												
Thomas G. Myers		Alice Ada Burpan												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
No		220 10 3579		I. P. Myers		Antietam, Sharpsburg, Md. 21781								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema														
4201 DUE TO minutes														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency 3 mo														
(c) Coronary sclerosis 1 yr														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1966</u> to <u>June 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 4, 1966</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>6/11/66</u>												
22a. SIGNATURE <u>Halvard Wanger</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Box 175		Shepherdstown, West Virginia								
22c. PHYSICIAN'S NAME (Type) Halvard Wanger, M.D.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 14-66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg, Md.								
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
John W. Miller		cont'd.		DATE JUN 14 1966		Signature								
VR A15 (4) 15M 4-64														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			09069		
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND WASHINGTON											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?					
HAGERSTOWN			11 DAYS			HAGERSTOWN			128 FAIRGROUND AVE.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL																	
3. NAME OF DECEASED (Type or print)		First NINA		Middle VIOLET		Last MYERS		4. DATE OF DEATH JUNE 10 1966		Month Day Year							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH SEPT. 21, 1889		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY			10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE			11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME JACOB MYERS						14. MOTHER'S MAIDEN NAME JEMIMAH WILEY											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-09-2295			17. INFORMANT KATHERINE CLARK			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 11 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) 1200 LEBANON ST.		(County) SILVER SPRINGS, MARYLAND		(State) MARYLAND				
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1937 , to June 10, 1966 , that (I) (we) last saw the deceased alive on Jun 11, 1966 , and that death occurred at 1201 M, from the causes and on the date stated above.												22b. DATE SIGNED 6/13/1966					
22a. SIGNATURE Lloyd A. Hoffman			22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M.D.			22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 6/14/1966			23c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN CEMETERY			23d. LOCATION (City, town or county) WASHINGTON CO., MARYLAND			(State)					
24. FUNERAL DIRECTOR CHARLES M. ROUZER			ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR JUN 16 1966			25b. REGISTRAR'S SIGNATURE Charles Judge								
25c. DATE																	



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08077

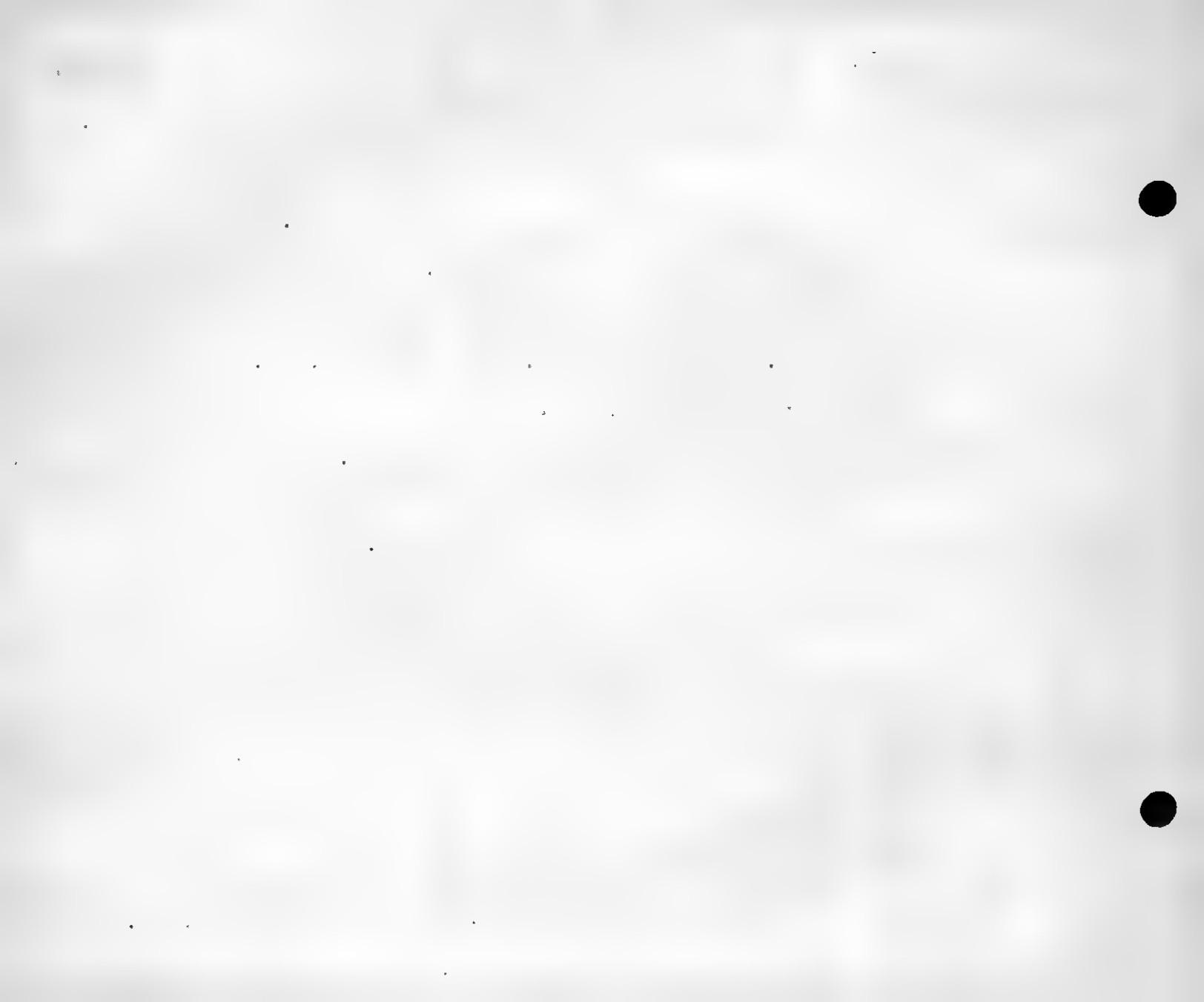
CERTIFICATE OF DEATH

09070

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 52 years		d. STREET ADDRESS 169 Manse Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Keller Nigh, Jr.		First	Middle
4. DATE OF DEATH June 9 1966	Lost	Month	Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/13
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
12. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanical Eng'r.		13. KIND OF BUSINESS OR INDUSTRY Electric Co.	
14. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		15. CITIZEN OF WHAT COUNTRY?	
16. FATHER'S NAME William Keller Nigh, Sr.		17. MOTHER'S MAIDEN NAME Sarah Mowen	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		19. INFORMANT Address Elizabeth H. Nigh Hagerstown, Md.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Anesthesia</u>		21. INTERVAL BETWEEN ONSET AND DEATH <u>4201</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial infarction</u>		22. <u>the</u>	
DUE TO (c) <u>Coronary atherosclerosis</u>		23. <u>Years</u>	
24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
28. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		29. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
31. (I) certify that (I) (this hospital) attended the deceased from <u>9 June 1966</u> to <u>9 June 1966</u> , that (I) (we) last saw the deceased alive on <u>9 June 1966</u> and that death occurred at <u>HIP M</u> , from causes and on the date stated above.		32. (City or town) (County) (State)	
33. SIGNATURE <u>J. Wilson</u>		34. DATE SIGNED 22b. M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
35. PHYSICIAN'S NAME (Type)		36. ADDRESS 22d.	
37. BURIAL, CREMATION, REMOVAL (Specify) Burial		38. DATE THEREOF 6/13/66	39. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery
40. FUNERAL DIRECTOR MINNICH FUNERAL HOME		41. ADDRESS Hagerstown, Md.	42. LOCATION (City or Town) (County) (State) Hagerstown, Md.
43. REC'D BY REGISTRAR		44. REGISTRAR'S SIGNATURE JUN 16 1966 <u>J. Wilson, Judge</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural				c. LENGTH OF STAY IN 1b 30 yrs							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Ohio Room HFD #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
John P. Peden			J	P	Peden	June	7	1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 29 1900		75 yrs.		5 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Sec. Prop. Co. for C. Co. Advertising Church				Industry				Pennsylvania			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Andrew Peden				Sophia Jones				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No				16. SOCIAL SECURITY NO.				17. INFORMANT			
				223 115 935A Mrs. Josephine Peden				Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion -</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4x01</i> <i>(b) general arteriosclerosis and coronary 70 year</i> DUE TO (c) <i>atherosclerosis -</i>											
INTERVAL BETWEEN ONSET AND DEATH <i>5 to 10 Min</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>											
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREATORY			
Burial				June 10-66				Greenlawn Cemetery			
24. FUNERAL DIRECTOR				ADDRESS				23d. LOCATION (City, town or county) (State)			
Allentown 102 Williamport Rd.								Williamsport, Pa.			
VR AISM (5) 5M 1/65				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
				DATE JUN 9 1966				<i>Charles Judge</i>			



M TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

00073

110072

1. PLACE OF DEATH
a. COUNTY

Washington MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

5 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Garlock Conv. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Pa. b. COUNTY Franklin

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural, Waynesboro

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ND

3. NAME OF
DECEASED
(Type or print)

First
Earl

Middle
H.

Last
Peiffer

4. DATE
OF
DEATH

Month
June
Day
19
Year
1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

2/6/1893

9. AGE (In years
last birthday)

73 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired Draftman

10b. KIND OF BUSINESS OR
INDUSTRY

Trick Co.

11. BIRTHPLACE (County & State, or foreign country)

Chambersburg Pa.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Peiffer

14. MOTHER'S MAIDEN NAME

Ellie Shenabrook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

173-03-1473

17. INFORMANT

Mrs. Melvin F. Ruppert, Waynesboro Pa., 1/4
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Recent

DOUE TO

(b) Arteriosclerotic Vascular Disease

Several years

DUE TO

(c) Carcinoma Of Bladder

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES ND

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-15, 1966, to 6-19, 1966, that (I) (we) last saw the deceased alive on 6-18, 1966, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE

E. W. Ditto

ATTENDING
M.D.
PHYS.

MED.
DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

6-20-66

22c. PHYSICIAN'S
NAME (Type)

Dr. E. W. Ditto, Jr.

22d. ADDRESS

215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

6/22/66

23c. NAME OF CEMETERY OR CREMATORIUM

Green Hill

23d. LOCATION (City, town or county) (State)

Waynesboro, Franklin Co., Pa.

24. FUNERAL DIRECTOR

Walter J. Grove

ADDRESS

Waynesboro Pa.

25a. REC'D BY REGISTRAR

JUN 22 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09073

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Washington		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1B	b. COUNTY Washington	
... o.n.	10 hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
Washington County Hospital			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Ethel	Eliz.	.h Potts
4. DATE OF DEATH	Month	Day	Year
June	7	1966	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 20 1906
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
59 yrs.	Clerk	Williamsport	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Joseph B. Moore	Susan Hull		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes give war or dates of service)		Robinwood Drive	Mr. William J. Potts, Dentist, ...
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure due to</u>			
Conditions, If any, which gave rise to Immediate causa (a), stating the underlying cause last. (b) <u>2°-3° Burns of 90% Body</u>			
DUE TO (c) <u>Surface</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>clothes caught fire while burning trash in yard</u>		
20c. TIME OF INJURY Month, Day, Year Hours <u>am</u> p.m. <u>6-6 - 1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Williamsport Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county) (State)
Burial	June 9-66	S. P. Ls Cemetery	Hagerstown, Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. st. ... apt. 17.	JUN 9 1966	Charles Juay

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Please execute the command:

VR AF5ME (5)
5M 1/65



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

20081

110174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE		MARYLAND		b. COUNTY		WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write name of nearest town)		HAGERSTOWN		c. LENGTH OF STAY IN lb 50 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN		d. STREET ADDRESS		111 RANDOLPH AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		111 RANDOLPH AVE.													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
CHARLES		ROY		REECHER	JUNE		8	19 66							
5. SEX		6. COLOR DR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS								
MALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/24/1886	79 yrs.	Months	Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
RETIRED CLERK		RAIL ROAD		MARYLAND		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
WILLIAM CHARLES REECHER		MARY ALICE PRYOR													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
NO		705-10-5665		MR. CHARLES R. REECHER JR.		MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arterios = Sclerotic Heart Disease												7 yrs.	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)													
		DUE TO (c)											7 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Diabetes Mellitus													
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY		Month, Day, Year	Hour a.m. p.m.	20d. INJURY OCCURRED	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)						
			19												
21. I certify that (I) (this hospital) attended the deceased from		Jan 8, 1966		to Jan 8, 1966		, that (I) (we) last saw the deceased alive on		Jan 8, 1966		and that death occurred at		SA M,		from the causes and on the date stated above.	
22a. SIGNATURE		<i>S. H. Beachley</i>												22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		<i>S. H. Beachley</i>				ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		<i>Hagerstown, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)								(State)	
BURIAL		6/10/66		REST HAVEN CEM.		HAGERSTOWN								MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
		<i>W. J. Norment, Hagerstown, Md.</i>		DATE JUN 15 1966		<i>Charles Judge</i>									



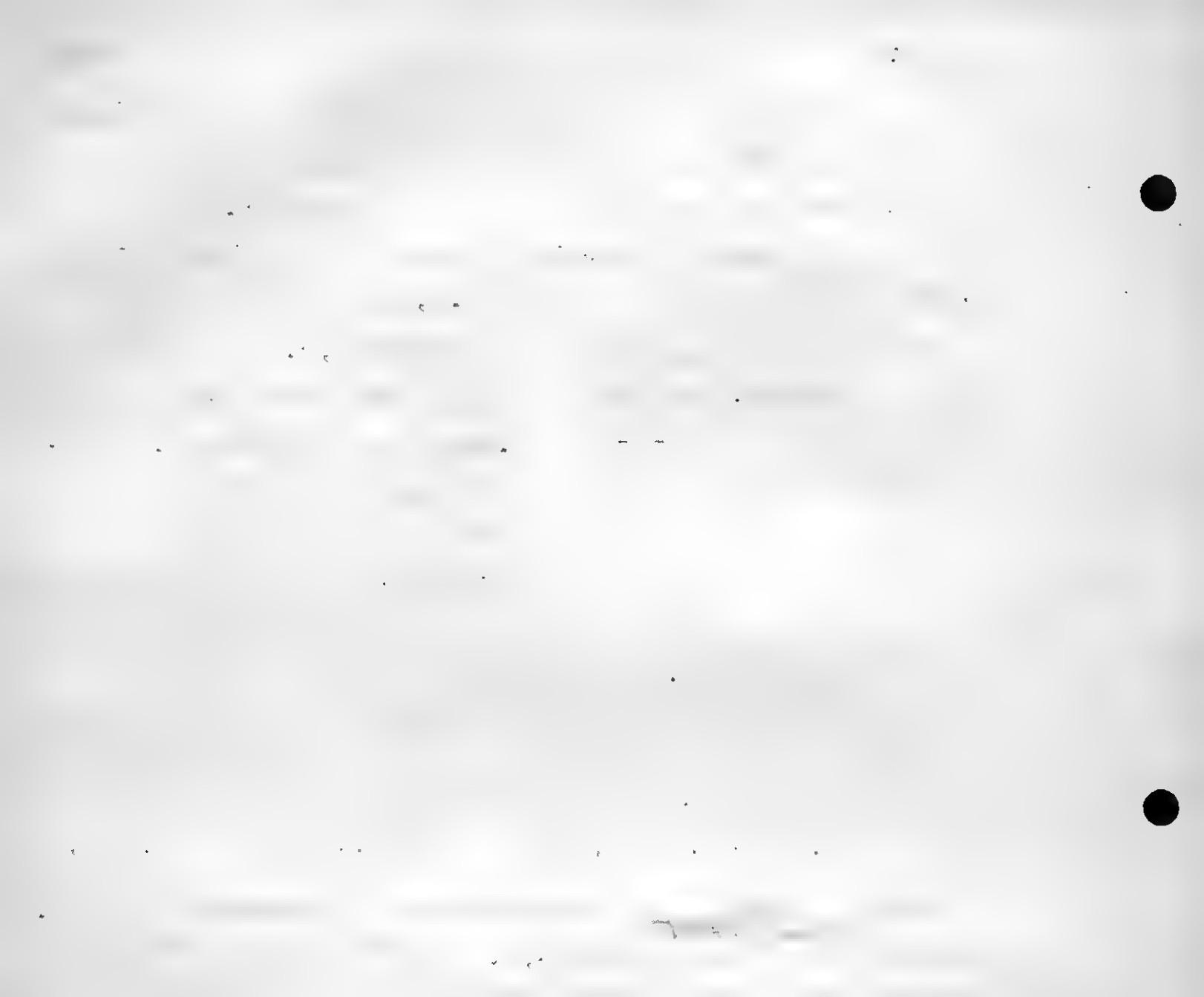
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 20 Belview Ave.	
3. NAME OF DECEASED (Type or print)		First Hazel	Middle Beatrice
4. DATE OF DEATH		Last Ritter	Month June Day 3 Year 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles William Ernde		14. MOTHER'S MAIDEN NAME Alice Florence Bryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 204-19-9751	
17. INFORMANT Mr. Leroy Ritter		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct			
1 d o l Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary thrombophlebitic occlusion rt coronary artery (c) DUE TO Coronary artery disease			
1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
		20f. (City or town) Hagerstown (County) Wash (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19 61, to June 19 66, that (I) (we) last saw the deceased alive on June 3 19 66, and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch, Jr.		22b. DATE SIGNED 6-3-66	
22c. PHYSICIAN'S NAME (Type) Dr. Harold R. Tritch, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 302 N. Potomac St Hagerstown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR Wm. C. Stroet		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
Rest Haven Funeral Chapel Hagerstown, Md.		JUN 6 1966	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09076

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10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>J. Robinette</i>	Last <i>Robinette</i>
4. DATE OF DEATH	Month 6	Day 3	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-15-82	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRICKLAYER	10b. KIND OF BUSINESS OR INDUSTRY LABORER	11. BIRTHPLACE (County & State, or foreign country) FLINTSTONE, ALLEGANY, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JOHN B. ROBINETTE	14. MOTHER'S MAIDEN NAME MARY ELIZABETH DAVIS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 200-07-1128	17. INFORMANT Mr. Herbert M. Ash	Address Flintstone, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis, General		DUE TO (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of hip			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-6-64 to 6-3-66 (at (I) (we) last saw the deceased alive on 6-3-66 , and that death occurred at 6-3-66 M, from causes and on the date stated above.)			
22a. SIGNATURE <i>Frank Ricco</i>	22b. DATE SIGNED 6-3-66		
22c. PHYSICIAN'S NAME (Type) FRANK RICCO	M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22d. ADDRESS 1510 Penna Ave. Hagerstown, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-6-66	23c. NAME OF CEMETERY OR CREMATORIAL T.O.O.F. Cemetery	23d. LOCATION (City or Town) (County) (State) Flintstone, Allegany, Maryland
24. FUNERAL DIRECTOR DALE L. MERRITT	ADDRESS 404 DECATUR ST. CUMB., MD.	25a. REC'D BY REGISTRAR JUN 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11/11/77

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 60 yrs.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			
3. NAME OF DECEASED (Type or print) Mary	First Mary	Middle Jane	Last Shaffer
4. DATE OF DEATH June 28 1966	Month June	Day 28	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1890
9. AGE (In years last birthday) 76 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Chambersburg, Penna.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME George Miller		
14. MOTHER'S MAIDEN NAME Florence Miller	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N		
16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Paul Shaffer 497 Mitchell Ave.	Address Hagerstown, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 15 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Cardiac dysrhythmia	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-16 , 19 66 , to 6-28 , 19 66 , that (I) (we) last saw the deceased alive on 6-28 , 19 66 , and that death occurred at Hagerstown , Md., from the causes and on the date stated above.	22a. SIGNATURE D.W.C. Morton	22b. DATE SIGNED 6/29/66	
22c. PHYSICIAN'S NAME (Type) D.W.C. Morton	22d. ADDRESS Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/2/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR W.W. G. Host	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE JUL 1 1966
VR A15 (4) 20M 1/65			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 090078

M I		22085			
1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Baltimore Convalescent Hospital		d. STREET ADDRESS RD # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LEWIS	Middle S.	Last SHANK	4. DATE OF DEATH Month June Day 7 Year 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/22/1877	9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ringgold, Ga.	
13. FATHER'S NAME Lewis Barkdoll		14. MOTHER'S MAIDEN NAME Annie Shank		12. CITIZEN OF WHAT COUNTRY? No	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 210-46-3156		17. INFORMANT W. Jennings Shetts RD 5, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH Recent	
(b) DUE TO		Cerebral sclerosis heart disease		15 years.	
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>6-7</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>5-20</u> , 19 <u>66</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 152 W Main Waynesboro Penn 6-8-66	
ACTUAL SIGNATURE - <u>Walter H. Wishard</u>		M.D.		DATE SIGNED	
PHYSICIAN'S NAME (TYPE) <u>Walter H. Wishard</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1966		22c. NAME OF CEMETERY OR CREMATORIAL Ringgold Cemetery	
22d. LOCATION (City, town, or county) Ringgold, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Merlin Roe</u>		ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR JUN 10 1966	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

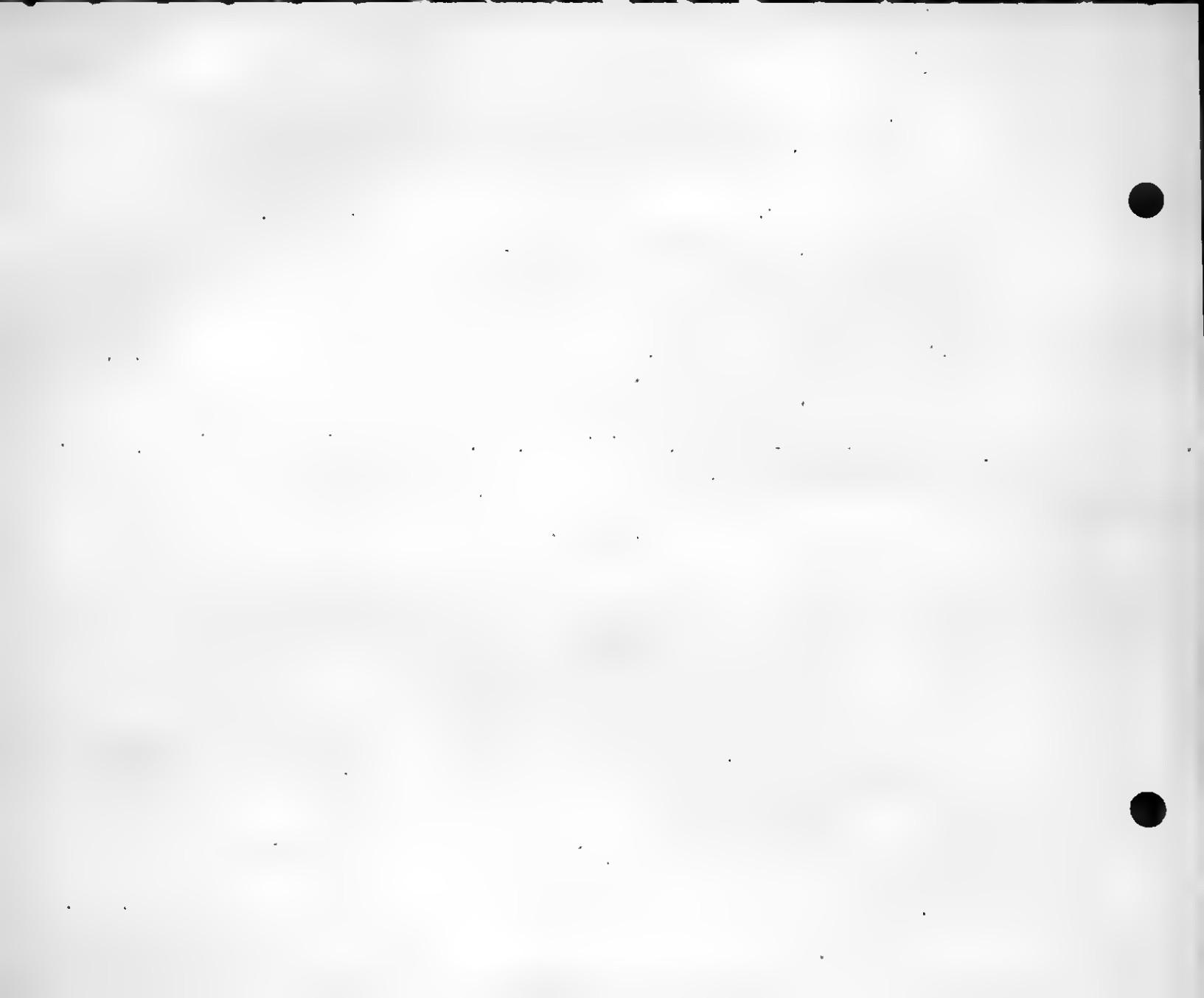
CERTIFICATE OF DEATH

09079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 29086		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1D 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
John		Thomas	Sherpherd
4. DATE OF DEATH		Month	Day Year
June		6	1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. UNDER 1 YEAR Months Days Hours Min.
July 15 1900		55 yrs.	10 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
Farmer		Farm	Maryland
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John J. Sherpherd		Jennie Kretzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		220-21-7225	17. Infrauent
			Address
			17 Main St. Apt. 802, Shady Side, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 hour	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arteriosclerotic heart disease	
(b)		4 months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arteriosclerotic heart disease	
(c)		4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
Pulmonary fibrosis		1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town)	(County)
		(State)	
21. I certify that (I) (this hospital) attended the deceased from 9-10- to 6-6-, 1966, that (I) (we) last saw the deceased alive on 6-6- 1966, and that death occurred at 10 th M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 6-7-68	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Joseph Secondari		Boonsboro MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		June 9-66	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Baltimore		Baltimore, Md.	
24. FUNERAL DIRECTOR		ADDRESS	
Albert J. Ladd Miller Corp. Inc.		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE	
		JUN 9 1966 Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE			b. COUNTY			89087 09080					
WASHINGTON MARYLAND			MARYLAND			WASHINGTON								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						HAGERSTOWN			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First JACK	Middle RICHARD	Last SHORT	4. DATE OF DEATH JUNE 22 19 66	Month JUNE	Day 22	Year 19 66					
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1918	9. AGE (In years last birthday) 48 yrs.	10. KIND OF BUSINESS OR INDUSTRY LABORER	11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME AS HBY SHORT	14. MOTHER'S MAIDEN NAME ANNA BLOSSER	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT RUSSELL SHORT	Address BALTIMORE, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia														
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Pulmonary Fibrosis														
(c) Pulmonary tuberculosis														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
INTERVAL BETWEEN ONSET AND DEATH 10 days 15 yrs 24 yrs														
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) NOV 6, 1966	(County) Hagerstown	(State) MD.
	19													
21. I certify that (I) (this hospital) attended the deceased from NOV 6, 1966, to NOV 6, 1966, that (I) (we) last saw the deceased alive on NOV 6, 1966, and that death occurred at NOV 6, 1966, M, from the causes and on the date stated above.														
22a. SIGNATURE Donald E. Martin														
22b. DATE SIGNED 6/22/66														
22c. PHYSICIAN'S NAME (Type) Donald E. MARTIN MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF JUN. 26, '66			23c. NAME OF CEMETERY OR CREMATORIAL ADVENTIST			23d. LOCATION (City, town or county) STANLEY			(State) VA.		
24. FUNERAL DIRECTOR W.J. Normand, Hagerstown, Md.			ADDRESS			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE			DATE JUN 28 1966		
VR A15 (4) 2DM 1/65														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

M
CSC88

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09051

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		a. STATE		b. COUNTY				
c. LENGTH OF STAY IN 1b		—		Md.		Wash.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		WASH. CO. HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN - MAUGANSVILLE				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
KATIE B.				SHOWALTER	JUNE	13		1966		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.			
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/10/1883	83 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housewife		Home		Franklin Co., Pa.		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Peter Shank		Martha Grove								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
NO		—		Alvah M. Showalter		Maugansville Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO <u>Se conds</u>										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebothrombosis, Rt Intimal Saphenous</u> 7 days (c) <u>Cerebral Arteriosclerosis with hemiparesis</u> 2 weeks										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Carcinoma of Stomach</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (This hospital) attended the deceased from <u>Feb</u> , 19 <u>78</u> , to <u>6-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> , 19 <u>66</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.		22e. SIGNATURE <u>Dalton M. Welty</u>		22b. DATE SIGNED <u>6/14/66</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22d. ADDRESS		22d. ADDRESS		22d. ADDRESS		
Dalton M. Welty, M.D.		998 N. Potomac Ave. Hagerstown, Md.		998 N. Potomac Ave. Hagerstown, Md.		998 N. Potomac Ave. Hagerstown, Md.		998 N. Potomac Ave. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)		
Burial		6/16/66		Reiff Church Cem.		Clearfoss, Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
A. E. Mennich - Greencastle Penna.		DATE JUN 17 1966		DAN		CHARLES JUDGE				
132										
VR A15 (4) 15M 4-64										



FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09082

1. PLACE OF DEATH a. COUNTY WASHINGTON	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	b. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
4 MILES WEST OF HANCOCK ACCIDENT		d. STREET ADDRESS FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First EDWARD	Middle JOSEPH	Last SHUCK	4. DATE OF DEATH JUNE 25, 1966	Month JUNE	Day 25	Year 1966
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1923	9. AGE (in years last birthday) 43	10. IF UNDER 1 YEAR Months 43	11. IF UNDER 24 HRS Hours hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY VOCATIONAL REHABILITATION - STATE		11. BIRTHPLACE (State or foreign country) WESTERNPORT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME JOHN C. ARNOLD	14. MOTHER'S MAIDEN NAME CECELIA HEALY	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. W.W. II	17. INFORMANT 218-16-4643 MRS. HARMON ARNOLD, 40 MAPLE ST.,	Address FROSTBURG, M.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fractured skull & massive
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Brain Injury (c) Fractured Neck
		DUE TO (c) Chest Injury - Crushing type

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Struck tractor trailer which was turning on highway		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:00 p.m. 6-24-1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> I.S. #70	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hancock Wash Md	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *E. W. Ditto* CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) **E. W. DITTO 111-217 W. WASH. ST.** M.D. ASSISTANT MEDICAL EXAMINER
REDACTED DEPUTY MEDICAL EXAMINER

22. DATE SIGNED
6-25-66

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City, town or county) (State)

BURIAL JUNE 28, 1966 SUNSET MEM. PARK CUMBERLAND, MARYLAND

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Marilou Sowers HAFER FUNERAL HOME JUN 30 1966 *Charles Judge*

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and by my event within 72 hours after death.

To: [REDACTED] 55-111 TT[REDACTED]

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09090 09053

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Gladys	Middle Elizabeth	Last Smith
4. DATE OF DEATH Month June	Day 22	Year 1966	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8 1913
9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Private family	11. BIRTHPLACE (County & State, or foreign country) Hagerstown Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Anderson	14. MOTHER'S MAIDEN NAME Bessie Simpson	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-42-3962	17. INFORMANT Mrs. Minnie M. Johnson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease			
(c) Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH 16 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4N.?			
10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 214 N. Potomac St.	20f. (City or town) (County) (State)
21. I certify that (I) (his/hospital) attended the deceased from 1956 to JUNE 22 1966 , that (I) (we) last saw the deceased alive on JUNE 22 1966 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Carol A. Hoffmann	22b. DATE SIGNED 6/24/66		
22c. PHYSICIAN'S NAME (Type) Liccy A. Hoffmann	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS 214 N. Potomac St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-25-1966	23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR John R Watson Jr. Hagerstown Md.	ADDRESS	25a. REC'D BY REGISTRAR JUN 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 1/65			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09091 09084

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS LITTLE ORLEANS	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle CECIL	Last SMITH SR.
4. DATE OF DEATH Month JUNE	Day 5,	Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
13. FATHER'S NAME OLIVER SMITH		14. MOTHER'S MAIDEN NAME CHRISTINA CHAMBERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-36-9441	
17. INFORMANT MRS. RUTH E. JONES		219 th CLOVER HEIGHTS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebrovascular insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>440X</i> (b) <i>innumerable emboli</i> (c) <i>hypertensive heart disease with right atrial thrombus and patent foramen ovale</i>		weeks <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>thrombus and patent foramen ovale</i>		WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>June 14</i> 1966, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>John C. Shaffer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/17/66	
23c. NAME OF CEMETERY OR CREMATORIUM PINEY PLAINS CEMETERY		23d. LOCATION (City, town or county) (State) ALLEGANY CO., MARYLAND	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR <i>not</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

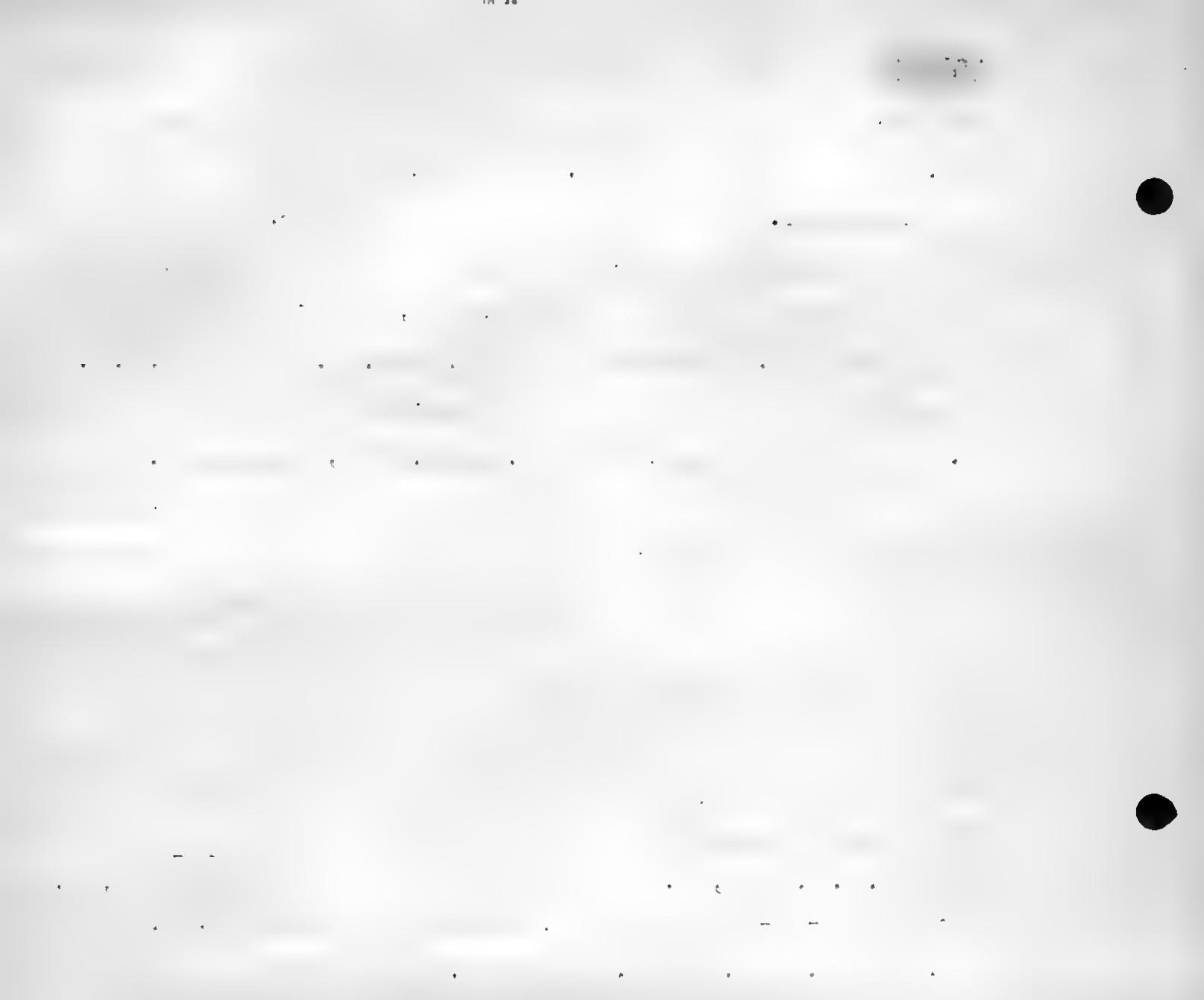


1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				09392 09055									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown									
c. LENGTH OF STAY IN 1b 21 Yrs.													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) East Oak Ridge Dr.				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Howard	Last Smith	4. DATE OF DEATH	Month June 18,	Day 19	Year 66					
5. SEX		6. COLOR OR RACE Male	White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1890	9. AGE (in years last birthday) 76 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS				
			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>			Months 2	Days 6	Hours 2	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY Automobile				11. BIRTHPLACE (State or foreign country) St. James. Md.					
13. FATHER'S NAME Joseph Smith				14. MOTHER'S MAIDEN NAME Mary Long				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 213-12-7430				17. INFORMANT Mrs. Edna L. Smith, Funkstown, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				Several years									
(b) Acute Bronchitis DUE TO				Several weeks									
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)									
ACTUAL SIGNATURE 				22. DATE SIGNED 6-18-66									
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-66		23c. NAME OF CEMETERY OR CREMIATORIUM Rest Haven Cemetery		23d. LOCATION (City, town or county)		(State) Hagerstown, Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				ADDRESS				25a. REC'D BY REGISTRAR		25d. REGISTRAR'S SIGNATURE			
								JUN 22 1966					





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08093

09096

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
WASHINGTON MARYLAND		b. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL HAGERSTOWN 5 YRS.		RURAL HAGERSTOWN / /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MT. TABOR ROAD			
3. NAME OF DECEASED (Type or print) ERNEST		First WALTER	Middle SPADE
4. DATE OF DEATH JUNE 26		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE (In years last birthday) 38 yrs.
FOREMAN			11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ALEXANDER K. SPADE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16. SOCIAL SECURITY NO. W.W. II	17. INFORMANT MRS. PEGGY SPADE
		212-24-3622	MT. TABOR ROAD R.D.#.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion -		10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease c 5 yrs.			
DUE TO DUE TO (c) Coronary Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
			20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Edward W. Ditto III		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO III M.D. 217 W. WASH. STREET, HAGERSTOWN, MD. 6/28/1966		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 30, 1966	23c. NAME OF CEMETERY OR GREA TORY BROADFORING CEMETERY
			23d. LOCATION (City, town or county) (State) WASHINGTON CO., MARYLAND
24. FUNERAL DIRECTOR CHARLES M. ROUZER		ADDRESS HAGERSTOWN, MARYLAND	25a. REC'D BY REGISTRAR JUL 5 1966
			REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09087

1
09096
1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Rural Hagerstown

c. LENGTH OF STAY IN lb

2 WKS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Gateway Convalescent Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

W.

John

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

7-5-1892

23 yrs.

9. AGE (in years
last birthday)

Months Days

10. IF UNDER 1 YEAR

Hours Min.

10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Father Father

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State, or foreign country)

13. FATHER'S NAME

Edward Spangler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

John S. Spangler, Wm. J. Spangler, Jr.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Annie Sollenberger

Address

INTERVAL BETWEEN
ONSET AND DEATH

2 3 hrs

0

yes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

REYNOLDS DISEASE

Arteriosclerotic Nephrosclerosis

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 16 June 1966 to 20 June 1966, that (I) (we) last saw the deceased alive on 20 June 1966, and that death occurred at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

W. N. FENDER

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
20 June 1966

22d. ADDRESS

218 N. Potowmack St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

Prices Cemetery

23d. LOCATION (City, town or county)

Franklin & Anna

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Franklin & Anna, Inc.

ADDRESS

Hagerstown, Md.

25a. REC'D BY REGISTRAR

JUN 22 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

2015

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		09095		09088											
1. PLACE OF DEATH a. COUNTY		Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown				c. LENGTH OF STAY IN lb		17 Days				a. STATE Pa.		b. COUNTY Franklin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Garlock Conv. Hospital				d. STREET ADDRESS		29 E. 2nd. St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Walter		Middle Robert		Last Sprenkle		4. DATE OF DEATH		Month June		Day 19		Year 1966	
5. SEX		6. COLOR DR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3/10/1882		84 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Custodian, Gardner				Adams Co., Fairfield #1		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Oscar Sprenkle		Eliza Shelley													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY ND.		17. INFORMANT		Address									
No		209-12-8662		R. Glenn Sprenkle,		Waynesboro Pa.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		15 m. 2													
4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)		Acute myocardial infarction											
		DUE TO (c)		Generalized arteriosclerosis.											
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		5 yrs.													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
19															
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to June 17, 1966, that (I) (we) last saw the deceased alive on June 1, 1966, and that death occurred at 77 M, from the causes and on the date stated above.															
22a. SIGNATURE		22b. DATE SIGNED													
<i>David R. Hess</i>		6/21/66													
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>									
David R. Hess, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)							
Burial		6/21/66		Grimstone Hill		Chambersburg Funeral, Franklin, Pa.									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Walter Y. Grove		Waynesboro Pa.		June 22 1966		<i>Charles Judge</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

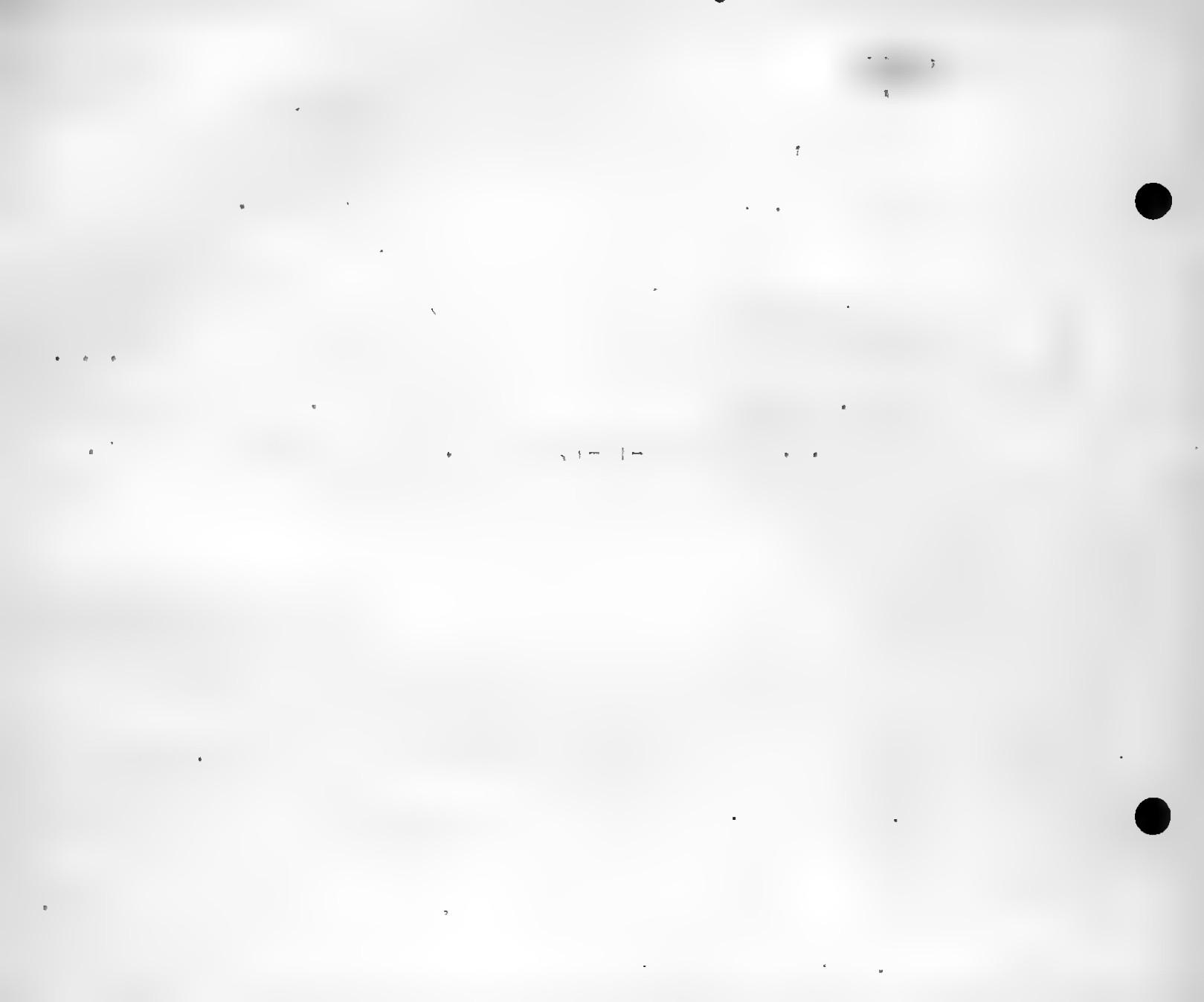
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1996 **09059**

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle ARTHUR	Last SPRINGER
4. DATE OF DEATH JUNE 16 1966	Month JUNE	Day 16	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1925
9. AGE (in years last birthday) 40 yrs.	10. KIND OF BUSINESS OR INDUSTRY BARTENDER	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HARRY C. SPRINGER	14. MOTHER'S MAIDEN NAME MINNIE G. PITZNOGLE	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) YES W.W.#2	
16. SOCIAL SECURITY NO. 1220-16-1907	17. INFORMANT MRS. THELMA SPRINGER	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid bleeding INTERVAL BETWEEN ONSET AND DEATH 4 hrs Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) cerebrovascular accident 4 hrs (c) hypertension 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) mashed ebony & diabetic tendency			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 1966 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1966 to June 16, 1966 , that (I) (we) last saw the deceased alive on June 16 1966 , and that death occurred at 4:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harold Ray Tritch Jr</i>	22b. DATE SIGNED 6/18/66		
22c. PHYSICIAN'S NAME (Type) Harold RAY Tritch JR	22d. ADDRESS Hagerstown, Md.		
23a. BURIAL, CREMATION, (Specify) BURIAL	23b. DATE THEREOF 6/20/66	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.
24. FUNERAL DIRECTOR W. J. Horment, Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR JUN 21 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19097		CERTIFICATE OF DEATH					09090					
1 PLACE OF DEATH a. COUNTY WASHINGTON		b. LENGTH OF STAY IN 16 MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			d. STREET ADDRESS 32 W. CHURCH ST.							
3 NAME OF DECEASED (Type or print) First CLARA Middle CATHERINE Last SPRINKLE		4 DATE OF DEATH Month JUNE Day 6 Year 1966			5 AGE (In years last birthday) yrs 78		6 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min					
5 SEX FEMALE		6 COLOR OR RACE WHITE		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5/9/1888		9 IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min				
10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (County & State, or foreign country) GREENSBURG, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN W. JACOBS			14. MOTHER'S MAIDEN NAME EMILLA E. PRICE			15. SOCIAL SECURITY NO. 212-38-8402		16. INFORMANT WALTER SPRINKLE Address 38 W. SALISBURY ST. WILLIAMSPORT, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Arterial thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 days		DUE TO Arterial thrombosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Arterial thrombosis										
(c) Cerebrovascular arteriosclerosis												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1966 , to June 6, 1966 , that (I) (we) last saw the deceased alive on June 5, 1966 , and that death occurred at M , from causes and on the date stated above.												
22a. SIGNATURE Charles C. Spencer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-9-66								
22c. PHYSICIAN'S NAME (Type) Charles C. Spencer		22d. ADDRESS 145 S. Prospect, Hagerstown										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/9/66		23c. NAME OF CEMETERY OR CREMATORIAL GREENLAWN CEMETERY		23d. LOCATION (City or Town) WILLIAMSPORT, MARYLAND		(County) (State)				
24. FUNERAL DIRECTOR Howard J. Stone Home and		ADDRESS		25c. REC'D BY REGISTRAR DATE JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						

200
200

200

1 M

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office alone with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in addition, within 72 hours after death.

Items 18&21 Film G378 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09098

09091

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN lb 50 yrs.	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 161 N. Jonathan Street		f. DATE OF DEATH Month Day Year June 10 1966	
3. NAME OF DECEASED (Type or print) Albert		Last	
First (none)		Middle	
4. DATE OF DEATH Month Day Year June 10 1966		4. DATE OF DEATH Month Day Year June 10 1966	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec 25 1895	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Charles Town W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Strothers		14. MOTHER'S MAIDEN NAME Sallie Queen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War I 216-14-5563	
17. INFORMANT Eva Spriggs		Address Charles Town W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1- Fatty metamorphosis liver, advanced			
DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (c) 2- Severe chronic pancreatitis 3- Diabetes mellitus, uncontrolled			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy - grand mal			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Edward W. Ditto III</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.	
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.		22. DATE SIGNED 6-13-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Md	
24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md.		25a. REC'D BY REGISTRAR DATE JUN 16 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

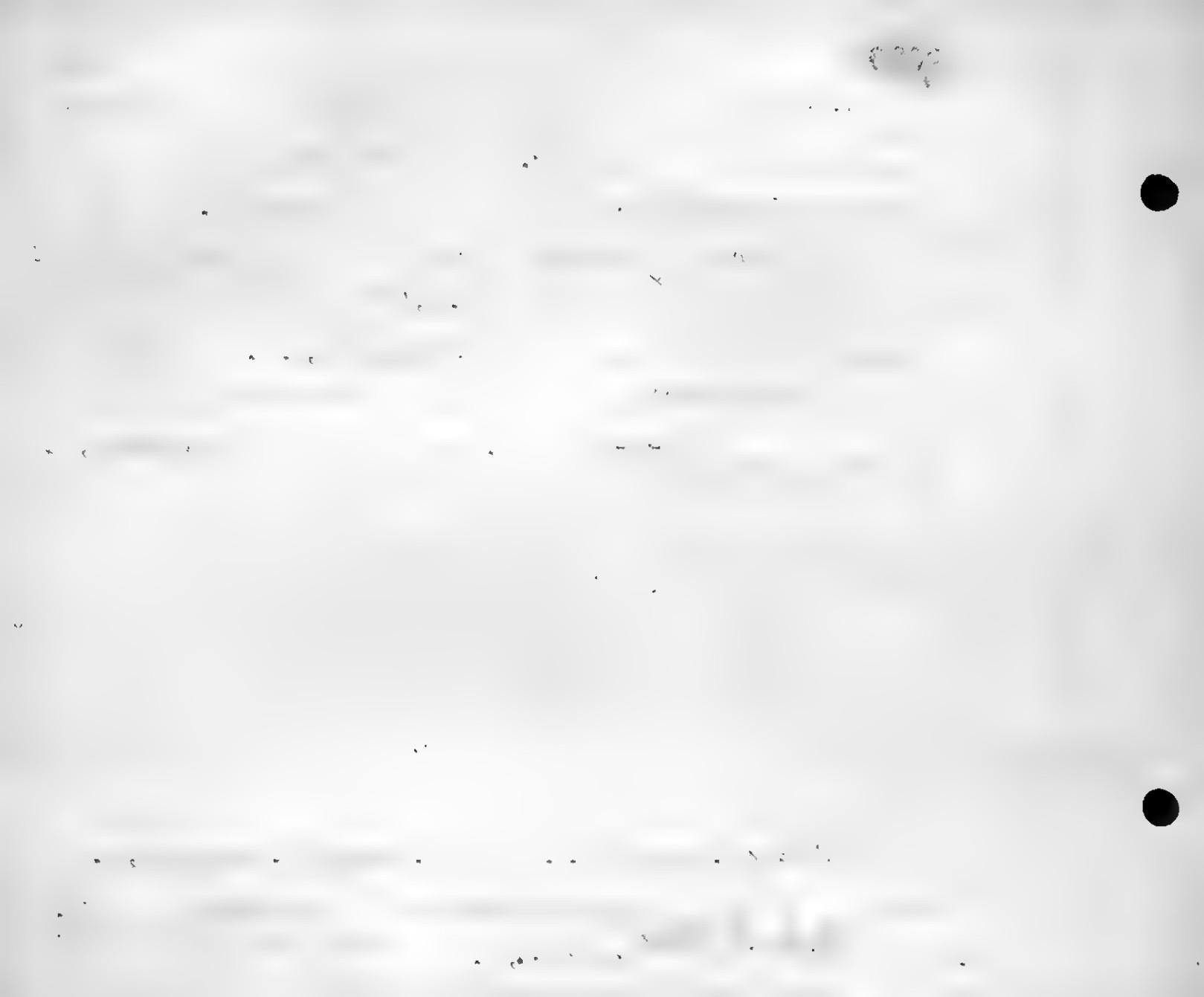
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

一一一〇九

1. PLACE OF DEATH a. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		50 yrs.		a. STATE Maryland b. COUNTY Washington			
c. LENGTH OF STAY IN 1b									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital									
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Harvey	Washington		Turner	June		3	1966		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS			
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Feb. 22, 1884	82 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Fireman		City Light Plant		Shepherdstown, W. Va.		USA			
13. FATHER'S NAME Joseph Turner								14. MOTHER'S MAIDEN NAME Emma Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-09-1258		Mrs. Leroy McClay		R # 3 Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia								1 day	
1501		DUE TO	Gangrene of left foot						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	Arteriosclerosis Obliterans						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that (I) (this hospital) attended the deceased from May 28, 1966, to June 3, 1966, that (I) (we) last saw the deceased alive on July 1, 1966, and that death occurred at 12:00 AM, from the causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE Charles C. Spencer M.D.								22b. DATE SIGNED 6/4/66	
22c. PHYSICIAN'S NAME (Type) Charles C. Spencer M.D.								22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/6/66		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown		(State) Md.	
Burial									
24. FUNERAL DIRECTOR Wm. C. Horst ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.								25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
								DATE JUN 6 1966 Charles Judge	

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2DM 1/65



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

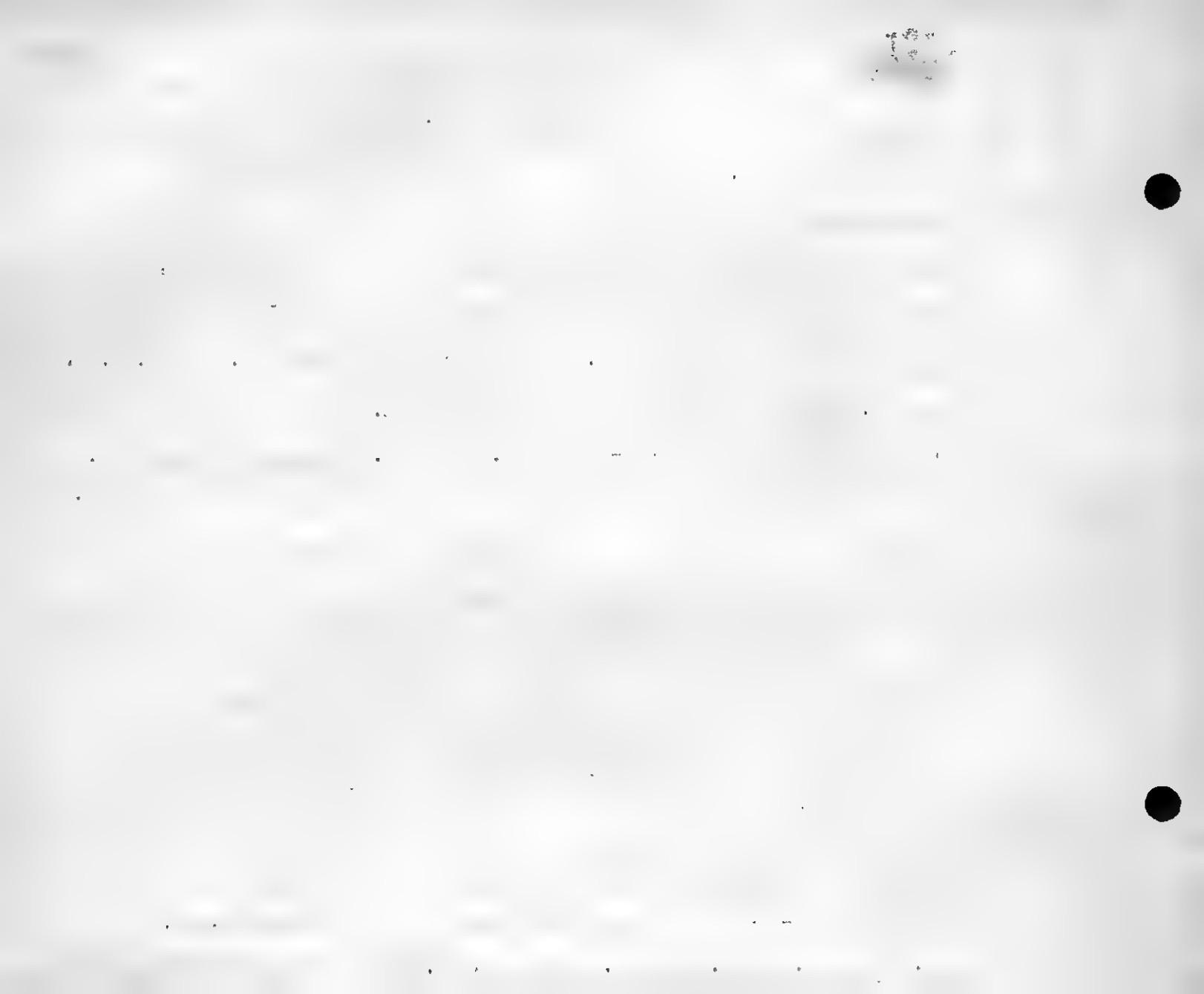
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09100

CERTIFICATE OF DEATH

09093

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Rural Boonsboro Rfd. 2		Life		Rural Boonsboro Rfd. 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clevelandville			d. STREET ADDRESS Clevelandville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Avoline		First Etta	Middle Wagaman	4. DATE OF DEATH June 5, 1966	Month June	Day 5	Year 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 11, 1919	9. AGE (In years last birthday) 47 yrs	11. UNDER 1 YEAR 1 Months	12. UNDER 24 HRS 24 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.		11. BIRTHPLACE (County & State, or foreign country) Rural Boonsboro Rfd. 2		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard W. Morgan			14. MOTHER'S MAIDEN NAME Amanda E. Smith			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-16-1901		17. INFORMANT Mr. Marlin L. Wagaman, Boonsboro Rfd. 2, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			acute dilation of heart - Chronic pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 8 hours 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to June 5, 1966 , that (I) (we) last saw the deceased alive on June 3, 1966 , and that death occurred at Boonsboro, Md. from causes and on the date stated above.						22b. DATE SIGNED 6/6/66	
22a. SIGNATURE <i>G. W. Heelan</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) G. W. Heelan		22d. ADDRESS Boonsboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-66		23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS REC'D BY REGISTRAR JUN 9 1966 REGISTRAR'S SIGNATURE Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09101

09094

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Co. Hospital

**3. NAME OF
DECEASED
(Type or print)**

Nannie**MARYLAND****5 days****Middle****Last**

5. SEX

Female**6. COLOR OR RACE****White****WIDOWED****7. MARRIED****NEVER MARRIED****8. DIVORCED****9. B. DATE OF BIRTH****November 24, 1874****10. KIND OF BUSINESS OR INDUSTRY****Housework****11. BIRTHPLACE (County & State, or foreign country)****Huntington Co., Penna.**

13. FATHER'S NAME

James M. Cree

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **16. SOCIAL SECURITY NO.**

(Yes, no, or unknown) (If yes give war or dates of service)

No

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE**Penna.****b. COUNTY****Franklin**

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Greencastle

d. STREET ADDRESS

R.D. # 2**Last****4. DATE
OF
DEATH****Month****Day****Year****June 26,****1966****9. AGE (In years
last birthday)****91****10. IF UNDER 1 YEAR****Months****Days****Hours****Min.****11. IF UNDER 24 HRS.****Months****Days****Hours****Min.****12. CITIZEN OF WHAT COUNTRY?****U.S.A.****Mary Zimmerman**

14. MOTHER'S MAIDEN NAME

Address

Mr. C. Paul Weaver, Hagerstown, MarylandINTERVAL BETWEEN
ONSET AND DEATH

1 week

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral thrombosis-

332X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Generalized arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY
PERFORMED?YES NO **Uremia**

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from 5-23, 1960 to 6-26, 1966, that (I) (we) last
saw the deceased alive on 6-25, 1966, and that death occurred at 2 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Charles F. Hess

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
6-27-6622c. PHYSICIAN'S
NAME (Type)**Charles F. Hess, M.D.**

22d. ADDRESS

Smithsburg, Maryland23a. BURIAL, CREMATION, REMOVAL
(Specify)**Burial** 6/28/1966

23c. NAME OF CEMETERY OR CREMATORIUM

Rest Haven Cemetery

23d. LOCATION (City, town or county)

(State)

Hagerstown, Washington Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Harold M. Zimmerman, Greencastle, Pa.

ADDRESS

25a. REC'D BY REGISTRAR

DATE JUN 29 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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09102

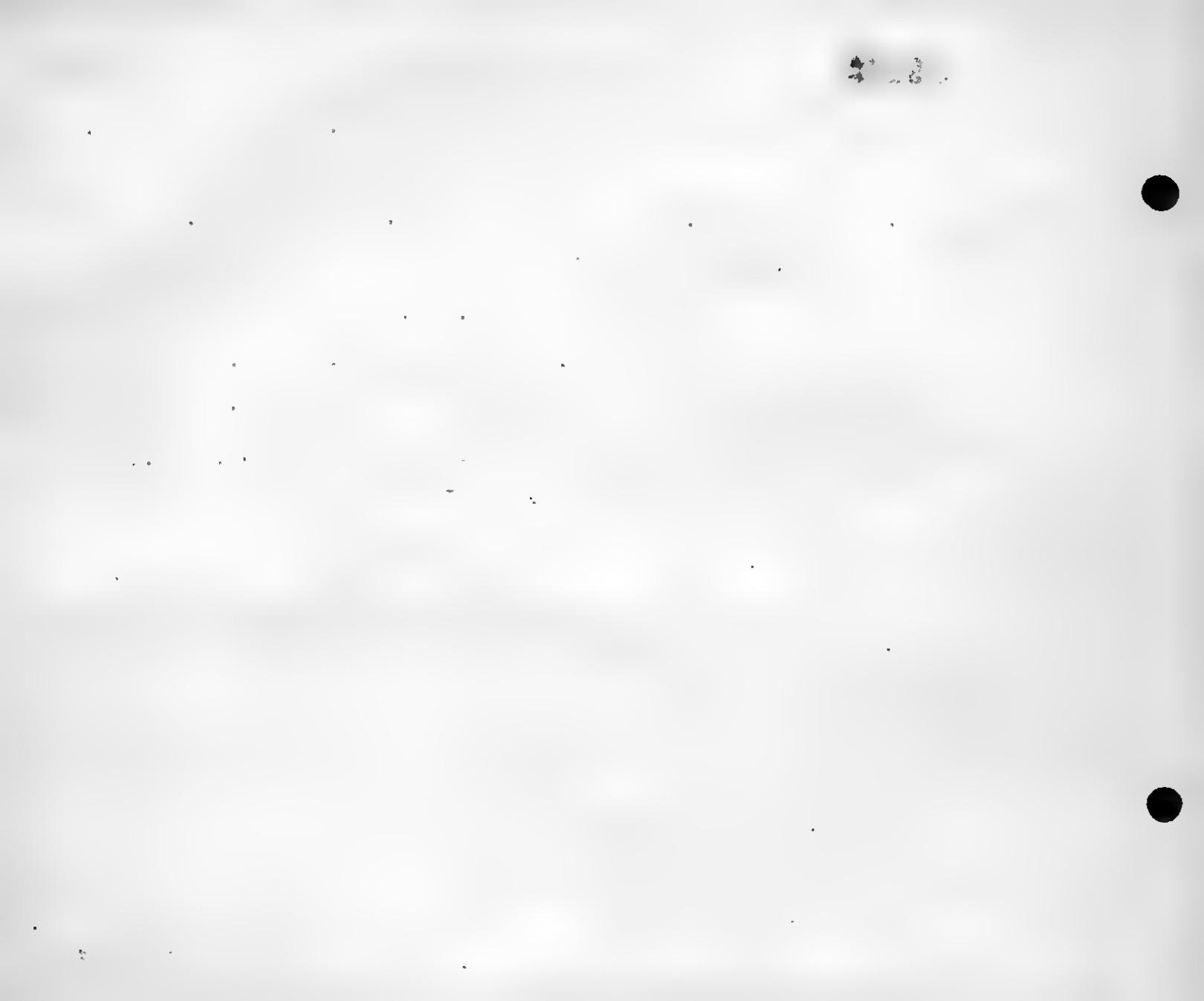
CERTIFICATE OF DEATH

09095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN lb 45 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 145 E. Baltimore St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 145 E. Baltimore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First WILLIAM	Middle AUGUSTUS	Last WEDDLES
S. SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) driver		10b. KIND OF BUSINESS OR INDUSTRY Express Co.	11. BIRTHPLACE (County & State or foreign country) Waynesboro, Penna.
13. FATHER'S NAME Charles Weddles		14. MOTHER'S MAIDEN NAME Effie J. Woodring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 212-14-7591	17. INFORMANT Address Mrs. Carolyn Weddles, Hag., Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction due to DUE TO (b) Arterio sclerotic H. D. DUE TO (c) Emphysema & Pulmonary Fibrosis		INTERVAL BETWEEN ONSET AND DEATH sudden Sept 1964	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 30, 1964, to June 11, 1966, that (I) (we) last saw the deceased alive on June 10, 1966, and that death occurred at 030 AM, from causes and on the date stated above.			
22a. SIGNATURE Sidney Movestine		22b. DATE SIGNED 6-14-66	
22c. PHYSICIAN'S NAME (Type) SIDNEY MOVESTINE, M.D.		22d. ADDRESS FUNKSDOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 6-14-66	23c. NAME OF CEMETERY OR CREMATORIAL Price Cemetery	23d. LOCATION (City or Town) (County) (State) rural Waynesboro, Pa.
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REGISTERED BY REGISTRAR JUN 16 1966 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09108

CERTIFICATE OF DEATH

09096

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death!

1 PLACE OF DEATH a. COUNTY WASHINGTON		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RAY	Middle WILSON	Last WELLER
4. DATE OF DEATH Month 6	Month 1	Doy 19	Year 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.19.1894
9. AGE (In years at birthday) 72 yrs		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) FULTON COUNTY PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS WELLER		14. MOTHER'S MAIDEN NAME CLARA SECRIST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 219.20.4917	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 DUE TO <i>Acute pyelonephritis & uramia</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Antricardioventric heart disease		(b) DUE TO <i>Antricardioventric heart disease</i> UNKNOWN	
(c) DUE TO <i>Congestive splenomegaly (Banti's syndrome)</i>		" "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 154 West Washington St., Hagerstown, Md.
20f. (City or town) (County) (State)		22b. DATE SIGNED	
21. I certify that (I) (this hospital) attended the deceased from 1725 1966 , to 611 1966 , that (I) (we) last saw the deceased alive on 1731 1966 , and that death occurred at 3A M, from causes and on the date stated above.			
22a. SIGNATURE <i>John H. Hornbaker</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6.4.66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CEDAR LAWN
24. FUNERAL DIRECTOR Howard & Stone Hancock md		25a. REC'D BY REGISTRAR JUN 7 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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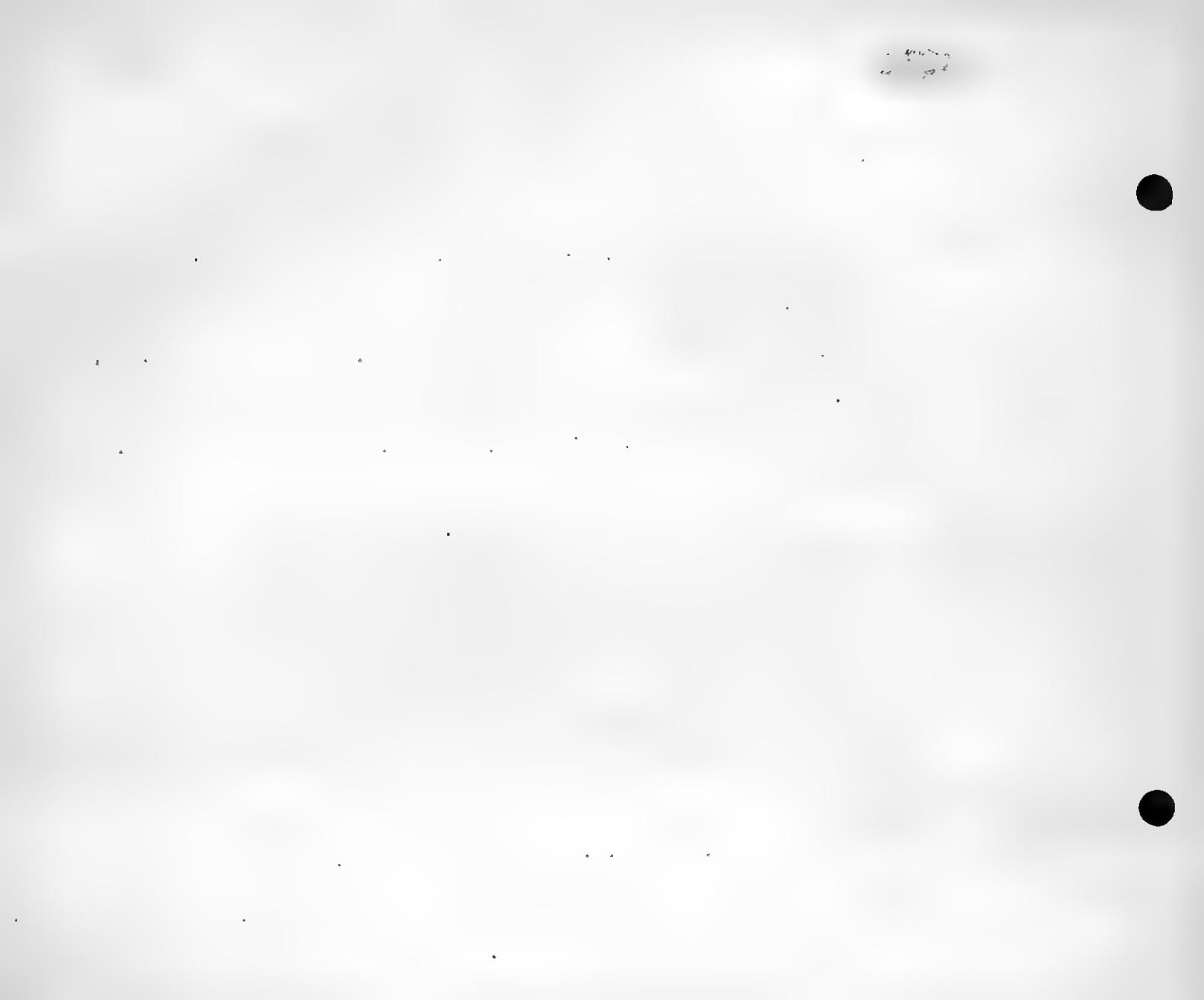
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 C9104		2 09097	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade		c. LENGTH OF STAY IN 1b 78 Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Cascade	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Allen West		4. DATE OF DEATH June 25 1966	Month Day Year
5. SEX Male White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/31/1878		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Maryland Railroad		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Lantz Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William F. West	
14. MOTHER'S MAIDEN NAME Margaret Ott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-12-1059		17. INFORMANT Mr. Kelso W. West,	Address Cascade Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 20 days.	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease		10 yrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-22, 1966, to 6-25, 1966, that (I) (we) last saw the deceased alive on 6-14 1966, and that death occurred at 7:00 AM, from the causes and on the date stated above.		22b. DATE SIGNED 6-25-66	
22a. SIGNATURE Charles F. Hess		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/66	23c. NAME OF CEMETERY OR CREMATORIAL Bethel
24. FUNERAL DIRECTOR Walter H. Grove,		23d. LOCATION (City, town or county) Waynesboro Pa.	23d. LOCATION (City, town or county) Tantz Md. Washington Co. Md.
25a. REC'D BY REGISTRAR DATE JUN 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09105

119098

CERTIFICATE OF DEATH														
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)										
a. COUNTY		WASHINGTON		a. STATE		MARYLAND		b. COUNTY		WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN		c. LENGTH OF STAY IN 1b		2 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				128 E. WASHINGTON ST.										
WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First GEORGE		Middle WILLIAM		Last WINTERS		4. DATE OF DEATH		Month JUNE	Day 29	Year 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.		
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12/6/1871		94 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
RETIRED SALESMAN				SHOE CO.				ENGLAND				U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME										
GEORGE W. WINTERS				ANNA ESTILL										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1]								
NO		287-09-9009		MRS. MARIE KEEDY		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Pneumonia DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 20 hrs				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Dec 10, 1966, to June 29, 1966, that (I) (we) last saw the deceased alive on June 29, 1966, and that death occurred at 3:00 AM, from the causes and on the date stated above.										22b. DATE SIGNED 6/30/66				
22a. SIGNATURE L. L. Packer		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22d. ADDRESS 145 W. Washington St., Hagerstown, Md.				
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/1/66		23c. NAME OF CEMETERY OR CREMATORIUM ST. PETERS R.C. CHURCH		23d. LOCATION (City, town or county) HANCOCK MD.				(State)				
24. FUNERAL DIRECTOR W. J. Torment, Hagerstown, Md.		ADDRESS				25a. REC'D BY REGISTRAR JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						
VR A15 (4) 2DM 1/65														

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1 M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09099

OS106

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN 1b

5 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASHINGTON COUNTY HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First
ANNA

Middle
MILDRED

Last
ZACCARIA

4. SEX

6. COLOR OR RACE

FEMALE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SUPERVISOR

10b. KIND OF BUSINESS OR INDUSTRY

HOISERY CO.

4. DATE
OF
DEATH

JUNE

7

Day
19
Year
66

8. DATE OF BIRTH

OCT. 31, 1908

9. AGE (In years
last birthday)

57

10. IF UNDER 1 YEAR
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

CALVIN B. HARTMAN

14. MOTHER'S MAIDEN NAME

FLORENCE MENTZER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214-09-4566

17. INFORMANT

MATTEO ZACCARIA

HAGERSTOWN, MARYLAND

818 MEDWAY ROAD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bilateral lobular Pneumonia -

8164

INTERVAL BETWEEN
DEATH AND DEATH

3 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO Fracture left Parietal Bone - temporal

(b) and Sphenoid Bone - Fracture and

due to Subdural Hemorrhage - Fracture Pelvis

(c) Hematoma Pelvis Peritoneum

4 days

19. WAS AUTOPSY
PERFORMED?

YES ND

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

occupant in Auto Struck by another car

20c. TIME OF INJURY Month, Day, Year

Hour

12:59 p.m.

June 31, 1966

20d. INJURY OCCURRED

While

at work

Not While

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Street

20f. (City or town)

Hagerstown

(County)

Wash. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Edward W. Ditto III

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22. DATE SIGNED

6/8/1966

EXAMINER'S
NAME (Type)

EDWARD W. DITTO III M.D. 217 W. WASH. ST., HAGERSTOWN, MARYLAND

Address Street, Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

6/10/1966

23c. NAME OF CEMETERY OR CREMATORIUM

REST HAVEN CEMETERY

23d. LOCATION (City, town or county)

HAGERSTOWN, MARYLAND

(State)

24. FUNERAL DIRECTOR

CHARLES M. ROUZER

HAGERSTOWN, MARYLAND

25a. REC'D. BY REGISTRAR

JUN 13 1966

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit, File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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